

# Oceania Care Company Limited - Trevellyn Rest Home & Hospital

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Trevellyn Rest Home and Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 27 June 2017    End date: 28 June 2017
<b>Proposed changes to current services (if any):</b> None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> 91	

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

## Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Trevellyn Rest Home and Village Oceania Healthcare Limited can provide care for up to 106 residents. Occupancy on the first day of the audit was 91. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. The service provides rest home and hospital level care.

The audit process included the review of policies and procedures, the review of residents and staff files, and observations and interviews with residents, families, management, staff and one medical officer.

The regional manager, who is currently standing in as the acting business and care manager until the newly appointed business and care manager (BCM) starts in the new position, is responsible for the overall management of the facility and is supported by the executive management team. Service delivery is monitored.

Improvements are required for the following; adverse event reporting, risk assessment, interRAI and restraint.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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On admission to the service, residents, families and enduring power of attorney are provided with information required prior to giving informed consent. Time is provided if any discussions and explanation are required relating to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service is accessible in information packs and displayed within the service. Residents and family members confirmed their rights are met, staff are respectful of their needs and communication is appropriate.

A complaints register is maintained. Complaints are managed as per timeframes in the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Oceania Healthcare Limited is the governing body and is responsible for the service provided at Trevellyn Rest Home and Village. The regional operations manager is currently acting as the business and care manager in a temporary role, and is qualified and experienced in management systems and processes. The clinical manager is new to the role and is therefore supported by the

clinical and quality manager (regional), the operations manager (regional) and the senior clinical and quality manager (national), regarding oversight of the service and clinical care.

Oceania Healthcare Limited has a documented quality and risk management system that supports the provision of clinical care at the service. Policies are reviewed at support office and are current. Quality and risk performance is conveyed through meetings at the facility and monitored by the organisation's management team through the monthly business status reports. Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators. Resident information is identifiable, accurately recorded, current, confidential, accessible when required and securely stored.

There are human resource policies around recruitment, selection, orientation, staff training and development that are implemented. A recent review of staffing levels has been completed and flexible shifts have been implemented to facilitate any rise in residents' acuity levels. Residents and family confirmed that staffing levels are adequate and residents and relatives have access to staff when needed.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The service works with Needs Assessment Coordination Services to ensure safe and appropriate entry into the service. Residents' needs are assessed on admission by registered nurses. Nurses use initial nursing risk assessments, including interRAI, for data collection to create initial care plans. Residents and/or their families contribute to care planning and evaluation of care.

Planned activities are managed by a diversional therapist and appropriate to the group setting. Resident and family interviews confirmed satisfaction with the activities programme. Activities are provided either within group settings or on a one-on-one basis.

There is an electronic medicine management system in place. Review of resident files confirmed administration records are accurate and there is timely review of medicines by the general practitioner. There were no residents self-administering medicines.

The menus are meeting national nutritional guidelines for older people, and have been reviewed by a registered dietitian. Residents verified satisfaction with meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

All building and plant comply with legislation, with a current building warrant of fitness in place. The environment is appropriate to the needs of the residents. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents are provided with accessible and safe external areas. Residents' rooms are an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Essential emergency and security systems are in place and fire drills completed every six months. Call bells are available to all residents and are monitored monthly.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.	Yellow	Some standards applicable to this service partially attained and of low risk.
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The service uses Oceania Healthcare Limited policies and procedures for restraint minimisation and safe practice, meeting the requirements of the standard. There are systems in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The restraint coordinator confirmed that enabler use is voluntary.

There were two residents using restraint and two residents using enablers on audit days.

The residents' files reviewed demonstrated that the service focuses on de-escalation processes, and restraint and enabler use is documented in residents' care plans.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.	Green	Standards applicable to this service fully attained.
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The infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection according to the requirements of the standard. Induction and orientation of new staff include training in infection control practices. The service has ongoing infection control education and training available for all staff.

The surveillance programme is appropriate for the size and complexity of the services provided. Surveillance of infections is occurring according to the descriptions of the processes in the infection control programme. Infection prevention and control data is collected, collated, analysed and reported through all levels of the organisation, including governance. Infection control surveillance data is benchmarked internally against other Oceania Care Company Limited facilities.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	46	0	2	2	0	0
Criteria	0	97	0	2	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	<p>Residents stated that they receive services that meet their needs and they receive information in relation to their needs. Staff receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme.</p> <p>Interviews with the staff confirmed their understanding of the Code. All staff have had training on the Code during the previous 12 months. Examples were provided on ways the Code is implemented in their everyday practice including: maintaining residents' privacy; giving residents choices; encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.</p> <p>The auditors noted respectful attitudes towards residents on the days of the audit.</p>
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed	FA	<p>The service information pack, which is given to all residents on admission, includes information regarding informed consent. The ABCM, CM and registered nurses (RNs) discuss informed consent processes with residents and their families during the admission process. The informed consent policy and procedure includes guidelines for consent for resuscitation/advance directives and resuscitation orders, van outings; photographs being</p>

choices and give informed consent.		taken and clinical treatments that require written confirmation for consent.  Resident files identified that informed consent is obtained. Interviews with staff and residents confirmed their understanding of informed consent processes.
Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Resident information relating to advocacy services is available at the entrance to the facility and in information packs provided to residents and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Staff training regarding advocacy services was last provided in 2017.  Family and residents confirmed that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	Families confirmed they could visit at any time and are always made to feel welcome. The service has an open visiting policy and residents may have visitors of their choice at any time.  Residents are encouraged to be involved in community activities and to maintain family and friend networks. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved. Complaint forms are available at the entrance of the facility. Staff, residents and family confirmed they knew the complaints process.  Evidence relating to each lodged complaint is held in the complaints folder and register. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner.  The CM is responsible for managing complaints and residents and family stated that these are dealt with as soon as they are identified. Residents and family members could describe

		their rights and advocacy services particularly in relation to the complaints process. One coroner enquiry has been lodged since the previous audit and this remains open.
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	The acting business and care manager (ABCM) and clinical manager (CM) discuss the Code with residents and their family on admission. Discussion relating to the Code is also included on the agenda and discussed at meetings. Resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private where appropriate. The posters displaying residents' rights and advocacy services are displayed in the facility in te reo Māori and English.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>The service ensures that each resident has the right to privacy and dignity. The service has a philosophy that promotes dignity, respect and quality of life.</p> <p>The residents' own personal belongings are used to decorate their room in the hospital and rest home. There are regular presbyterian and catholic church services held in the facilities chapel and a chaplain is employed 20 hours a week. The activities programme provides a range of activities and outings and residents are encouraged to engage in community activities that they were involved in prior to been admitted into the facility. Care plans reviewed evidenced that resident's independence and wishes are identified in assessments and documented in their plan of care.</p> <p>A policy is available for staff to assist them in managing resident/patients practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for residents and patients.</p> <p>Staff confirmed that they knock on the door and identify themselves verbally before entering the room. This was observed on the days of the audit. Residents/patients and families confirmed that residents/patients' privacy is respected. Some communal showers did not have locks and /or engaged signs, one of these doors was modified accordingly on the days of the site visit and the others were to be modified once parts were available.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports or on the incidents/accident forms reviewed in residents' files. Residents,</p>

		<p>staff, family and the general practitioner confirmed that there was no evidence of abuse or neglect. Staff interviewed were aware of the need to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.</p> <p>Resident/patients files reviewed confirmed that cultural and/or spiritual values and individual preferences are identified.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The organisation has a Māori health plan which outlines how to work with Māori and the relevance of the Treaty of Waitangi. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan.</p> <p>A review of residents' files confirmed that specific cultural needs are identified in the residents' care plans. The clinical quality manager (CQM) stated that a kaumātua can be accessed by the service to support staff on tikanga protocols and general advice. Staff are aware of the importance of whānau in the delivery of care for the Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Staff and resident interviews confirmed there are choices for residents regarding their care and services. Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the residents' cultural values and beliefs. The initial care plan, the long-term care plan and InterRAI assessment are based on this information.</p> <p>The facility has access to DHB interpreting services when required. There is a multicultural staff mix who can translate for the current residents. Families are predominantly used as interpreters and advocates.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The service implements policies and procedures based on good practice, current legislation and guidelines. Staff confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. Staff training includes discussion of the staff code of conduct and prevention of inappropriate care. This training is covered in the orientation programme and the mandatory annual training programme delivered by Oceania Health Care Ltd. There were no complaints recorded in the complaints register for the previous 12 months relating any form of discrimination.</p> <p>Job descriptions include the responsibilities of position including ethical issues relevant to the role. Staff complete orientation and induction includes recognition of discrimination,</p>

		abuse and neglect. Staff confirmed their understanding of professional boundaries.
Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard.	FA	<p>Oceania Healthcare Ltd implements polices to guide best practice which are current, and have a document control system to ensure the polices are reviewed, researched and align to the Health and Disability Services Standards. The organisation's quality framework includes their internal audit programme. There is a training programme for all staff and staff are encouraged to attend and complete training. The service supports staff to attend external training provided.</p> <p>Residents and families expressed a level of satisfaction with the care delivered.</p>
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents sign an admission agreement on entry to the service. This provides information around what services are provided by the service. The admission agreements reviewed were signed on the day of admission. Staff are familiar with how translating and interpreting services can be accessed. Residents interviewed confirmed that they are well informed about their care and environmental changes.</p> <p>Policies and procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident/accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms. Family contact is recorded in residents' files. Family and residents confirmed that they are invited to the care planning meetings and are informed when the residents' meetings are scheduled. Families confirmed they are well informed.</p>
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Trevellyn Home and Hospital is part of the Oceania Care Company Limited with the executive management team including the chief executive officer and general manager, regional operational manager and clinical and quality manager providing support to the service. Communication between the clinical and quality manager, the regional operations manager and the business and care manager takes place on a regular basis (at least once a month), with more support provided as required. Currently there is an interim management structure.</p> <p>Oceania Care Company Limited has a clear mission, values and goals and staff interviewed could describe these. These are displayed in the service.</p> <p>The facility can provide care for up to 106 residents requiring rest home or hospital level of</p>

		<p>care. During the audit, the occupancy was 91; (57 residents requiring rest home level care and 34 requiring hospital level care). No additional contracts were held on audit days.</p> <p>The regional operations manager is currently standing in as the acting business and care manager until the newly appointed BCM starts. The clinical manager is a registered nurse with a current annual practicing certificate and evidence of at least eight hours training in management related topics. The clinical manager provides clinical oversight of the service.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Due to the CM not being in the role long enough to stand in for the BCM, the service has a process in place that in the absence of the BCM, the operations manager or the CQM (regional) stands in. This is the current management structure. These roles are also supported by the national clinical and quality manager.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Trevellyn Rest Home and Village uses the Oceania quality and risk management framework to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Oceania support office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hardcopy. New and revised policies are presented to staff to read and staff sign to evidence that they have read and understood the new/revised policy.</p> <p>Service delivery is monitored through review of incidents and accidents; complaints management; surveillance of infections; pressure injuries; soft tissue/wounds; and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues completed. Internal audits are completed in line with the quality audit schedule, with evidence of corrective actions identified and implemented.</p> <p>Monthly staff meeting minutes, including quality improvement, health and safety, and infection control. Evidence reviewed demonstrated communication with all staff around all aspects of quality improvement and risk management. There are bi-monthly resident meetings that keep residents informed of any changes. Staff reported that they are kept informed of quality improvements. Family are invited to come to the resident meetings.</p> <p>Health and safety policies and procedures are documented along with a hazard</p>

		<p>management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly with a facility health check completed quarterly by the clinical and quality manager</p> <p>The satisfaction survey for family and residents was completed in 2017 and reflected the satisfaction of the residents and family.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>The management team are aware of situations in which the service would need to report and notify statutory authorities, including, police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks and changes in key managers. The Ministry of Health and district health board would be notified of any sentinel event. Four of the four pressure injuries that were identified as 'stage 3', were notified to the Ministry of health as requested by the audit team during the site visit and evidence was provided the following day.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand the adverse event reporting process and could describe the importance of recording near misses. Information gathered around incidents and accidents is analysed with evidence of improvements put in place. All incident and accidents forms reviewed did not have designations documented, this was also noted in the resident's files as inconsistent practice.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>All staff complete an orientation programme and health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Health care assistants confirmed their role in supporting and budding new staff. A new staff member interviewed confirmed they had an orientation programme. The registered nurses hold current annual practising certificates along with other health practitioners in the service. Staff files included appointment documentation including signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal.</p> <p>The organisation has a mandatory education and training programme with an annual training schedule documented. Annual competencies are completed by clinical staff and evidence of completion of competencies is kept on staff files. Staff attendances are documented for internal training provided with some registered nurses and health care</p>

		<p>assistants attending.</p> <p>Education and training hours are at least eight hours a year for each staff member. Seven of the registered nurses have interRAI training and staff have completed training around pressure injuries in 2016.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy. Following a recent staffing review, flexible shifts have been implemented to cover any increase in the acuity levels. Healthcare assistants also provide kitchen services in their roles.</p> <p>There are 92 staff, including the management team, clinical staff, a diversional therapist, and household staff. There is always a registered nurse on each shift. The ABCM and CM are on call after hours. Residents and families confirmed staffing is adequate to meet the residents' needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered on admission, with the involvement of the family.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff described the procedures for maintaining confidentiality of resident records, relevant resident care, and support information can be accessed in a timely manner.</p> <p>Entries were legible, dated and signed by the relevant health care assistant, registered nurse or other staff member, including their designation. Resident files are protected from unauthorised access by being locked away in the nurse's stations for both the rest home and hospital wings.</p> <p>Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual resident files demonstrated service integration.</p>
Standard 1.3.1: Entry To Services	FA	Residents' entry processes into the service are recorded and implemented. Needs

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>assessments are completed for rest home and hospital level of care. The organisational information pack is available for residents and their family. The admission agreement defines the scope of the service, includes all contractual requirements and evidenced resident and/or family sign off.</p> <p>Interviews with residents and family and review of records confirmed the admission process was completed by staff in a timely manner.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Resident exit, discharge or transfer is not always managed in a planned and coordinated manner, resulting in interRAI assessments not always being timely (see 1.3.3.3). There is open communication between the resident and the family.</p> <p>At the time of transition, appropriate information is supplied by the provider to the services responsible for the ongoing management of the resident. Referrals are documented in the residents' progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication areas evidenced appropriate and secure medicine dispensing systems, free from heat, moisture and light. Medicines are stored in original dispensed packs. The drug registers are consistently maintained with registered nurses completing weekly checks. Six-monthly physical stocktakes are undertaken by the pharmacy. The medication refrigeration temperatures are completed and recorded.</p> <p>Staff authorised to administer medicines have current competencies. Administration records and specimen signatures are maintained. Staff education in medicine management is provided.</p> <p>Electronic medicine charts evidenced current residents' photo identification, legibility, as required (PRN) medication is identified for individual residents and correctly prescribed. Three monthly medicine reviews are completed and discontinued medicines are dated and signed by the GPs. The residents' medicine charts record all residents' medication.</p> <p>The service's policies provide guidelines and processes for residents to self-administer medicines. At the time of the audit there were no residents who self-administered medicine at the facility.</p>
Standard 1.3.13: Nutrition, Safe Food, And	FA	Registered nurses complete dietary assessments on admission. Each resident has a

<p><b>Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>dietary profile developed. Personal food preferences of the residents, special diets and modified nutritional requirements are known to the kitchen manager and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, was sighted. Nutritional re-assessments were not completed for all residents who experienced changes to their health status/condition (see 1.3.4.2).</p> <p>Residents' files demonstrated monthly monitoring of individual residents' weight. Interviews with residents stated their satisfaction with the food service. Residents' individual preferences are met and adequate food and fluids is provided.</p> <p>Resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Fridge temperatures are monitored three times per day and food temperatures are monitored twice a day. The kitchen staff have all attended food safety training.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>Processes are in place to inform residents and family of the reasons why services had been declined, should this occur. Referral agencies are informed of the reasons for decline of entry. Residents and/or their family are referred to more appropriate services in the area. The residents would be declined entry if not within the scope of the service or if a bed was not available.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Moderate	<p>The service has processes in place to seek information from a range of sources, for example: the resident; family; GP; specialist and the referrer. Policies and protocols are in place to ensure continuity of service delivery.</p> <p>The residents' files evidenced discharge and/or transfer information from the district health board (DHB) where required. The service has appropriate resources and equipment. The assessments are conducted in a safe and appropriate environment, usually the resident's room, including visits from the GP. Interviews with residents and families confirmed their involvement in care planning, review and treatment.</p> <p>There is a requirement for improvement relating to risk assessments; including interRAI assessment reviews to be conducted when the resident's condition changes.</p>

<p><b>Standard 1.3.5: Planning</b></p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Residents' care plans are individualised, integrated and up to date. Recorded interventions do not consistently reflect the risk assessments relating to the level of care required (see 1.3.4.2). InterRAI assessments are not consistently completed by RNs to inform the person centred care plans (see 1.3.3.3 and 1.3.4.2).</p> <p>The short-term care plans are developed for the management of acute problems, when required, and signed off by the RN when problems are resolved. Interviews with residents confirmed they have input into their care planning and review.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Residents' care plans evidence interventions based on initial assessed needs, desired outcomes and goals of residents. The GP documentation and records are current. Interviews with residents and families confirmed current care and treatments meet residents' needs. The service maintains family communication records in resident files. Nursing progress notes and observation charts are maintained by staff.</p> <p>Staff confirmed they are familiar with the needs of the residents who were allocated to their care.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Interviews with the diversional therapist (DT) confirmed the activities programmes meet the needs of the residents. The auditor reviewed the programmes for February to June 2017. The DT plans, records, implements and evaluates the activities programmes.</p> <p>The service has one activities programme for the rest home and hospital. Regular exercises and outings are provided for those residents able to participate. The activity programmes includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.</p> <p>There are current, individualised activity care plans in residents' files. The residents' activities attendance records are maintained. Residents' meeting minutes evidenced residents' involvement and consultation of the planned activities programme.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. Change is noted and reported to the RN. Care plan evaluations and assessments occur every six months however, not when the residents' condition changes (see 1.3.4.2).</p> <p>Short-term care plans are initiated for short-term concerns, such as: infections; wound care;</p>

manner.		changes in mobility and other short-term conditions. Short-term care plans are reviewed daily, weekly or fortnightly, as indicated on the plan. The wound care plans evidence timely reviews.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service has processes in place to provide opportunities for residents to choose when accessing or when being referred to other health and/or disability services. The family communication sheets, located in the residents' files, confirmed family involvement. The service has a multidisciplinary team approach. Progress notes and communication records confirmed residents and their family are advised of their options to access other health and disability services.
Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place and incidents are reported on, in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirements for labels to be clear, accessible to read and free from damage.  Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education in safe and appropriate handling of waste and hazardous substances.  There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas. Chemicals are stored in a designated shed with chemical hazard signs.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed. There have been no building modifications since the last audit.  There is a planned and reactive maintenance schedule implemented. The service has an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment occurring annually. Interviews with staff and observation of the facility confirmed there is adequate equipment.  There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are internal courtyards and lawns, areas

		with shade and outdoor table and chairs.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	<p>There are adequate numbers of accessible toilets/bathing facilities. All toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence.</p> <p>Auditors observed residents being supported to access communal toilets and showers, in ways that are respectful and dignified.</p>
Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Equipment was sighted in rooms requiring this with sufficient space for the equipment, staff and the resident.</p> <p>Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own. There are designated areas to store mobility aids, hoists and wheelchairs. The hospital rooms are large enough to accommodate specific aids.</p>
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	<p>The service has lounge/dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>The dining areas have ample space for residents. Residents can choose to have their meals in their room</p>
Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service	FA	<p>Laundry is completed on site, with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry. Laundry staff are required to return linen to the rooms. Residents and family members stated that the laundry standard met their requirements. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners have a</p>

<p>is being provided.</p>		<p>lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. Cleaners were observed to be vigilant on the days of the audit around keeping the trolley in sight.</p> <p>All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.</p> <p>Cleaners and laundry staff stated they receive monthly training from the company that provides chemicals</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>An evacuation plan has been approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. A fire drill is completed six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>There is always at least one staff member with a first aid certificate on duty with most staff having completed and have current first aid training.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency, including food, water, blankets, emergency lighting and gas ovens in the kitchen and a Bar-b-que.</p> <p>An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas, including the hallways and dining rooms. Call bells are monitored to ensure that they are answered promptly and that all are operational. Residents and family stated there are prompt responses to call bells.</p> <p>The doors are locked in the evenings. Staff complete a check in the evening that confirms security measures have been put in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature.</p> <p>There is a designated external smoking area for residents.</p>

comfortable temperature.		Family and residents confirmed that rooms are maintained at an appropriate temperature.
Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The Oceania infection prevention and control policies and procedures manual provides information and resources to inform staff on infection prevention and control. Strategies are in place to prevent exposure of infections to others. The responsibility for infection control is clearly defined in the infection prevention and control policy, including the responsibilities of Oceania's national infection control committee; infection control nurse and the infection control team.  There is a signed infection control nurse job description outlining responsibilities of the position. The infection control nurse is supported in their role by the business and care manager, the clinical and quality manager, the clinical manager and the infection control team. The infection control nurse is a registered nurse.
Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICN has access to relevant and current information, appropriate to the size and complexity of this service. Infection control is an agenda item at the facility's meetings. The internal audit programme includes infection control audits to monitor their implementation of the infection control programme.
Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. Policies are accessible to all personnel.  The infection control policies and procedures are developed and reviewed regularly in consultation and input from relevant staff and external specialists. Infection control policies and procedures identify links to other documentation in the facility.
Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers,	FA	The infection control education is provided to all staff. Infection control forms are part of staff orientation and education occurs as part of the ongoing in-service education programme. Interviews with staff advised that clinical staff identify situations where infection

support staff, and consumers.		<p>control education is required for a resident, including hand hygiene and cough etiquette. A registered nurse completed additional training for the role as the infection control nurse. The infection control staff education is provided by the ICN, RNs and external specialists. Education sessions have evidence of staff attendance and content of the presentations. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews.</p>
<p><b>Standard 3.5: Surveillance</b> Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control nurse is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at staff facility meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained. Residents' files evidenced the residents' who were diagnosed with an infection, had a short-term care plan in place.</p> <p>In interviews, staff reported they are made aware of any infections through verbal handovers, short-term care plans, progress notes and communication with RNs and the clinical manager. There have been no outbreaks since the previous audit. The facility's surveillance data is benchmarked against other Oceania facilities and this information is shared with staff and management.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b> Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The Oceania wide policy is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded in procedures. There were two residents at the facility using restraints and two residents using enablers during the on-site audit. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.</p> <p>Interviews with staff and staff records confirmed that restraint minimisation and safe practice (RMS), enabler usage and de-escalation education and training is provided. Oceania support office maintain records of restraint use and analysis is completed monthly by the business and care and clinical and quality managers. National results indicated there has been a reduction in restraint used for the organisation due to the use of low/low beds and the use of perimeter mattresses.</p>

<p><b>Standard 2.2.1: Restraint approval and processes</b></p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The national clinical and quality team are responsible for approving any form or type of restraint practice used throughout Oceania facilities. Oversight of restraint use at individual Oceania facilities is the responsibility of restraint coordinators.</p> <p>The restraint coordinator at Trevellyn is a registered nurse (RN). The responsibilities for this role are defined in the position description, sighted. The restraint coordinator has completed training in restraint minimisation and restraint management relevant to their role and could communicate their knowledge relating to the restraint minimisation standard. Restraint use has reduced from seventeen to two restraints over a period of five months.</p> <p>Restraints are authorised following an assessment of the resident. The approval includes consultation with other members of the multidisciplinary team. The restraint consent forms evidenced consent for restraint is obtained from a GP, restraint coordinator and the resident and/or a family member.</p>
<p><b>Standard 2.2.2: Assessment</b></p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>PA Low</p>	<p>The service records culturally safe practices, identification of desired outcomes and possible alternatives to restraint.</p> <p>During assessing on whether restraint will be used, appropriate factors are taken into consideration by suitably skilled staff, however restraint risks and monitoring timeframes are not consistently identified in the restraint assessment records. This is a requirement for improvement.</p>
<p><b>Standard 2.2.3: Safe Restraint Use</b></p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Protocols on safe use of restraint detail the processes of assessment, approval and implementation. These protocols guide staff in the safe use of restraint. Strategies are implemented prior to the use of restraint to prevent the resident from incurring injury, for example: the use of low beds and sensor mats.</p> <p>The policies that guide staff in the safe use of restraint include approved forms of restraint; restraint indications; associated risks; safety precautions; authorisation; reporting and monitoring requirements.</p> <p>Induction and orientation as well as training and education include restraint processes. Evidence of ongoing education regarding restraint and challenging behaviours was evident. Restraint competency testing of staff is included in their education process. Staff monitoring restraint are overseen by registered nurses and the clinical manager (CM).</p> <p>The restraint register is up to date and records necessary information to provide an</p>

		auditable trail of restraints. Health care assistants are responsible for monitoring and recording restraint monitoring processes when restraints are in use.
Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint.	FA	Evaluation of restraint occurs through measuring relevant clinical key performance indicators. Each individual episode of restraint is evaluated. The clinical files of residents using restraint evidenced the restraint evaluation forms are completed.  The restraint minimisation team meeting minutes evidenced evaluation of each restraint used in the facility. Residents and the family are involved in the evaluation of the effectiveness and needs for continuing restraint. Progress notes verified restraint related records.
Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint.	FA	Three monthly monitoring and annual quality reviews are conducted relating to the use of restraint/enablers. Restraint committee meetings are held monthly. Senior staff and registered nurses attend. The restraint coordinator reports to management and to the support office on a monthly basis. Quality review findings and any recommendations are used to improve service provision and resident safety. The restraint minimisation policies are current and are available to guide staff.  Restraint minimisation and safe practice education is provided for all staff.

## Specific results for criterion where corrective actions are required

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Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	Staff understand the processes for reporting incidents, accidents and near misses, however the incident and accident records reviewed showed designations of staff are not consistently recorded.	i) twelve of twelve incident reports reviewed did not have staff designation recorded.  ii) residents' files reviewed evidence staff designation was not consistently documented.	Staff to consistently record their designations in all written documents.  90 days

Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Initial care plans are completed within 24 hours of admission. Resident long-term care plans are completed within the required six month timeframe. InterRAI assessments are required to be completed within three weeks of admission and as of January 2017 all historical interRAI assessments are required to be completed. Two of fifteen resident files reviewed for interRAI assessments (the initial sample of ten was increased by five), did not provide evidence of interRAI assessment being completed within the required timeframes.	Not all residents had current interRAI assessments completed.	All residents to have interRAI assessments completed.  30 days
Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	Although long term care plans evidenced changes when residents' condition change, interRAI reassessments are not completed when the residents' conditions changes. The organisation also requires their staff to complete additional risks assessments when the residents' condition changes. These additional risk assessments were also not completed.	Not all residents who experience changes to their condition have risks assessments, including review of their interRAI assessments, completed.	All residents who experience changes to their condition are to have risks assessments, including review of their interRAI assessment, completed.  60 days

<p><b>Criterion 2.2.2.1</b></p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <ul style="list-style-type: none"> <li>(a) Any risks related to the use of restraint;</li> <li>(b) Any underlying causes for the relevant behaviour or condition if known;</li> <li>(c) Existing advance directives the consumer may have made;</li> <li>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</li> <li>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</li> <li>(f) Maintaining culturally safe practice;</li> <li>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</li> <li>(h) Possible alternative intervention/strategies.</li> </ul>	PA Low	<p>The service had two restraints and two enablers being used during the on-site audit. Two restraints and one of the enablers were reviewed as part of the sample size. Both the restraints and the enabler reviewed during this on-site audit did not include risk identification of risks during the assessment processes. One of the monitoring timeframes for restraint was not identified during the assessment process.</p>	<p>Two of two restraint risks and the risks relating to the enabler use, were not identified during assessment. One of the two restraint assessment records also did not include the monitoring timeframes for this restraint.</p>	<p>All restraint and enabler assessments are to identify related risks and monitoring timeframes.</p> <p>90 days</p>
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## **Specific results for criterion where a continuous improvement has been recorded**

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this audit.

No data to display

End of the report.