

# Alaama Care Limited - Turama Home Rest Home

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## Introduction

This report records the results of a Provisional 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 The DAA Group 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:

**Legal entity:** Alaama Care Limited

**Premises audited:** Turama House Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 19 October 2017      End date: 20 October 2017

**Proposed changes to current services (if any):** This facility is having a provisional audit undertaken to establish the prospective owner's preparedness to provide health and disability services and the current level of conformity with the required standards.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 19

# 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.

## General overview of the audit

Turama House Rest Home provides rest home level care for up to 36 residents. Currently the facility is privately owned and existing members of the management team and one registered nurse have shared responsibilities between two facilities. The general manager and owner/director responsibilities go across all four facilities.

Residents and families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board to establish the prospective owner's preparedness to provide a health and disability service, and the current level of conformity with the required standards for the level of care offered.

The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the current and proposed management, staff, the visiting mental health community nurse and a general practitioner.

This audit has resulted in one area identified for improvement relating to inconsistency between assessed needs and interventions in place.

## **Consumer rights**

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with internal complaints resolved promptly and effectively. One complaint received via the Health and Disability Commissioner remains open.

## Organisational management

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective.

The current quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated.

Policies and procedures support service delivery and are current and reviewed regularly. Both the current owner and the prospective owner use the same off-site policy development company.

The human resources policies and procedures documented reflect current good practice. The current staffing levels meet contractual requirements. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review.

The prospective owner has developed a transition plan which identifies the mission statement, core values, philosophy, quality systems and growth plan. They have in-depth understanding of the requirements of the Health and Disability Services Standards requirements as they own and operate two other age care facilities, one being two minutes' drive from Turama House Rest Home.

The prospective owner has a growth plan which includes ensuring they maintain relationships with other health care providers, referral agencies and the local community. It is intended that the current nurse manager/registered nurse will be based at Turama House Rest Home whilst maintaining their role at the near-by facility. The owner will be directly involved in the overall supervision of the organisation. The transition plan identifies that staffing levels shall be determined by the numbers and level of care required by the resident mix in the facility at any given time.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained using hard copy files.

## **Continuum of service delivery**

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident and family to facilitate the admission.

Residents' needs are assessed on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and family interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is good. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A community van is hired for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by health care assistants, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## **Safe and appropriate environment**

The facility meets the needs of residents and was clean, with regular maintenance occurring. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are managed to meet legislative requirements. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

The prospective owner has no plans to change the footprint of the facility.

## **Restraint minimisation and safe practice**

The organisation has implemented policies and procedures that support a restraint free environment. This will be maintained by the prospective owner. A comprehensive assessment, approval and monitoring process is available in policy and procedures should restraint be required.

Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## **Infection prevention and control**

The infection prevention and control programme, led by the facility manager who is trained in infection control, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the facility's external infection control advisor, general practitioner or the gerontology nurse specialist. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, with data analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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	44	0	1	0	0	0
Criteria	0	91	0	1	0	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

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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Turama House Rest Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Staff were observed to gain consent for day to day care on an ongoing</p>

		basis.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. A family member and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. A family member interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints/concerns register reviewed showed that 32 minor concerns for 2017 have been fully addressed and one complaint had been received from the Health and Disability Commissioner (HDC) over the past year. This occurred on the 2 March 2017 and all responses have been sent within required timeframes. A letter dated 1 June 2017 from the HDC stated that it was a provisional decision to take no further action pending the complainant's response. A further letter from HDC stated that following the complainant's response further advice will be sought from an aged care nurse and psychogeriatrician. Action plans show any required follow up and improvements have been made where possible. The quality/facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the</p>

		<p>complaint process and what actions are required.</p> <p>The proposed new owner is aware of the outstanding HDC complaint.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</p> <p>The prospective purchaser operates two other aged care facilities, knows and understands consumer rights and is aware of the obligations in relation to consumer rights legislation.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training records.</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>There was one resident in Turama House Rest Home at the time of audit who identified as Māori. Interviews verify staff support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from residents and their whanau.</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>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</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>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a Code of Conduct as part of their individual employment contract. It is completed at commencement of employment. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>professionals, for example, gerontology nurse specialist, district nurses and mental health services for older persons, and education of staff by courses provided by the Auckland District Health Board (ADHB). The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for internal and external education to support good practice.</p> <p>Other examples of good practice observed during the audit included seeking access to specialist services when expertise in management of residents is deemed necessary.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and a family member stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed through the ADHB, however staff reported interpreter services were rarely required due to family members assisting if required and all present residents being able to speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business plan outlines the goals and objectives of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the owner/director showed adequate information to monitor performance is reported including financial performance, quality data, emerging risks and issues.</p> <p>Currently, the service is managed by the quality/facility manager who works across two facilities. She has been in the role for many years and holds a current practising certificate as an enrolled nurse. Responsibilities and accountabilities are defined in a job description and individual</p>

		<p>employment agreement. A registered nurse works one day a week at Turama House Rest Home and is on call for two facilities. There was a dedicated RN for Turama House Rest Home who worked two days a week, but this position was vacated three weeks prior to this audit. The day to day services are overseen by a healthcare coordinator who has worked at the facility since 2006. The quality/facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing education.</p> <p>The service holds contracts with Auckland District Health Board (ADHB) for Age Related Residential Care and on the day of audit 17 rest home level care residents were receiving services under this contract and two residents were receiving rest home level care services under a Ministry of Health Long Term Chronic Care under the age of 65 years contract. (Refer comments in section 1.3 regarding two residents who may require reassessment to a higher level of care. The prospective owner is aware of this.) There are two boarders who are private payers who receive hotel services only at the time of audit.</p> <p>The prospective owner stated they have full knowledge of what is required to meet contractual requirements.</p> <p>The transition plan identifies the governance structure, shows how services will be planned, coordinated and how resident needs will be met. All clinical oversight will be undertaken by a registered nurse with interRAI competency, who works as the current nurse manager of a facility owned by the intended purchaser and she will work across two sites but will be based at Turama House Rest Home during the transition period. Due diligence has been completed.</p> <p>The proposed takeover date is the 6 December 2017.</p>
<p>Standard 1.2.2: Service Management</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>	<p>FA</p>	<p>When the quality/facility manager is absent the general manager and owner/director undertake this role. During absences of key clinical staff, the clinical management is overseen by a registered nurse from a nearby facility who is experienced in the sector and able to take responsibility for any clinical issues that may arise. The healthcare coordinator role is covered by the quality/facility manager. Staff reported the current</p>

		<p>arrangements work well.</p> <p>The proposed owner understands their obligation to ensure appropriate cover is maintained for senior staff in case of absence.</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>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and wound care.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and risk team meetings, with the owner/director and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed that in 2016 there was an increase of 4.28% overall resident satisfaction from the previous year's results. Annual reports cover January to December each year. No comparisons had yet occurred for the 2017 resident satisfaction survey, but the results sighted show that residents are satisfied with services offered. This was confirmed during interviews with residents and family members. Actions have been taken in response to issues raised, such as ensuring residents' laundry is returned appropriately.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The general manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Members of the management team are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p>

		The proposed owner uses the same off-site policy development agency as the existing owner/director and policies will not change but will be updated to personalise procedures to reflect the new owners' philosophies. The transition plan sighted clearly describes how quality and risk management systems will be operated.
<p>Standard 1.2.4: Adverse Event Reporting</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>	FA	<p>Policy stated that adverse events will be documented on an accident/incident form. With the exception of a recently developed pressure injury for which no incident report was located (refer comments in criterion 1.3.3.3), samples of other incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owner/director and staff.</p> <p>The quality/facility manager and the general manager described essential notification reporting requirements, including for pressure injuries. They advised there had been no notifications of significant events made to the Ministry of Health. However, on the day of audit a section 31 report was filed related to a stage three pressure injury.</p> <p>No police investigations, coroner's inquests, issues based audits and any other notifications, such as public health outbreaks, have been made since the previous audit.</p> <p>The proposed new owner is aware of the requirements related to adverse event reporting. They stated no legislative compliance issues were identified as part of their due diligence.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The only staff records reviewed were non-registered staff as all management and registered staff files are kept at the facility which shares staff with Turama House Rest Home. No members of management or registered staff will be</p>

		<p>transitioning with the new proposed owner. They will remain with the current owner/director.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a 12-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either gained a senior status owing to longevity in the role (over five years), and/or completed a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB.</p> <p>The registered nurse who works between two facilities is maintaining their annual competency requirements to undertake interRAI assessments.</p> <p>The current owner/director was to commence advertising for a registered nurse to replace the registered nurse who left the position three weeks ago. However, it was decided at the closing meeting that the proposed new owner will fill the role with a registered nurse of her choice. Initially it will be the current nurse manager/registered nurse from the existing facility which is two minutes' drive away. They will be based at Turama House Rest Home. Once resident numbers increase a dedicated RN appointment will be made.</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>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of four weeks rosters confirmed adequate staff cover had been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p> <p>The proposed new owner has an interim roster documented in the transition plan to show how staffing levels will be maintained to meet</p>

		contractual requirements. Existing staff will be offered revised contracts.
<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 resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM). They are also provided with written information about the service and the admission process.</p> <p>A family member interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the ADHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services,</p>

		<p>appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner.</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>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a manual system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. There were no controlled drugs in use at the time of audit</p> <p>Medicines required to be kept in the fridge are stored in a sealed container in the kitchen fridge. The records of temperatures for the fridge and the storing of the medication were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There was one resident who self-administers medications at the time of audit. The medication is kept by the staff and given to the resident to administer unsupervised. Appropriate processes are in place to ensure this</p>

		<p>is managed in a safe manner.</p> <p>Medication errors are reported to the FM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in March 2017. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk</p>	FA	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an</p>

<p>to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. It has been suggested that two residents reviewed may require referral for reassessment, due to their high care needs. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one trained interRAI assessor on site.</p> <p>It was suggested that two residents who staff identified as requiring a high level of care, have their interRAI updated, and a review by the NASC (refer 1.3.6.1).</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Three of five care plans reviewed clearly reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed. However two resident files reviewed did not indicate recent changes in health status(refer 1.3.6.1)</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and family reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order</p>	<p>PA Low</p>	<p>Observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care, however the documentation was not consistently reflective of resident's</p>

<p>to meet their assessed needs and desired outcomes.</p>		<p>current required needs.</p> <p>The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Interview with the community mental health nurse described the service as "one of the best in the area" for meeting the diverse needs of these residents.</p> <p>Care staff confirmed that care was provided as outlined in verbal handovers, and not as per documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</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>	<p>FA</p>	<p>The activities programme is provided by a trained diversional therapist.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal three/six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included regular outings, walks to the local mall visiting entertainers, quiz sessions, exercise sessions and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the care co-ordinator or FM.</p>

<p>comprehensive and timely manner.</p>		<p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. With the exception of the acute episode mentioned (refer 1.3.6.1) examples of short term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, care co-ordinator or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff received safe use of chemicals, infection control requirements and safety data sheet training in February 2017. The general manager stated that if any new products are introduced to the facility the cleaning product company put in specific education for staff related to the safe use of the product. An external company is contracted to supply and manage all chemicals and cleaning products. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment</p>

		and staff were observed using this.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 15 June 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted. The maintenance schedule for 2016-2017 sighted showed that each item is signed off by the owner/director when completed.</p> <p>It was noted that the dining room chairs have chipped paint, the ranch slider from the television lounge was very heavy to operate and that three heaters in the hallway were showing signs of rust along the front vents. The prospective owner is aware of all these issues. There are no plans to make environmental changes to the facility footprint.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned. Residents stated they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes four shared toilets between two bedrooms, two bedrooms which have a toilet ensuite and one bedroom with a full ensuite. One of the shared toilets does not have a toilet seat. (Neither bedroom was occupied at the time of audit). The general manager stated that the toilet seat was removed owing to a resident requiring an elevated seat and that the appropriate toilet seat would be replaced. The prospective owner is aware of this.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to</p>

		promote residents' independence. The shared toilet and shower areas in the upstairs area of the rest home have been renovated and are in very good condition.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Two bedrooms are designated double bedrooms. Currently one is being used as office space for the management team. Both bedrooms would require a privacy curtain between beds if they are to be used for two residents. The proposed new owner is aware of this. All other bedrooms are single occupancy. Where rooms are shared approval would be sought. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms but stated that some bedroom doorways are too small to use a hoist if required.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. There is a downstairs dining/lounge area with a small kitchenette. Currently one resident and two boarders share this area. Upstairs there is a separate dining room and two separate lounge areas. The areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. It was noted that furnishings was an area raised in the resident satisfaction survey 2016 and the owner/director stated that some lounge room furnishings had been replaced.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry by cleaning/laundry staff and family members if they wish to do so. A notice sighted in one resident's bedroom stated the family wish to wash personal clothing for their relative. The cleaning/laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are usually returned in a timely manner. This topic was raised in</p>

		<p>the resident satisfaction survey and additional staff education was put in place.</p> <p>The cleaning/laundry staff received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. The service has a current hazardous substance register.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme which was last conducted in February 2017 with cleaning gaining a 95.83% rating and laundry gained 97.44% rating. Appropriate follow up actions for both audits were documented.</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>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in June 2000. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 12 April 2017. The next trial evacuation is booked for the 27 October 2017 as confirmed in documentation sighted. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water and blankets were sighted and meet the requirements for the 36 residents. Water storage is in an outdoor tank and bottles located in an internal storage cupboard. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time by afternoon staff. Staff stated they feel safe at all times.</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 comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by gas in the communal areas and electric wall mounted heater or free standing fin heaters in residents' rooms. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from an external advisor. The infection control programme and manual are reviewed annually.</p> <p>The FM, with input from the care co-ordinator, is the designated infection control nurse (ICN), whose role and responsibilities are defined in a job description.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN has appropriate skills, knowledge and qualifications for the role. The ICN has undertaken training in IPC and attended relevant study days, as verified in training records sighted. Subscription to an external advisory network enables expert advice, with input available from the gerontology nurse specialist and the GP if required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICN confirmed the availability of resources to support the programme and any outbreak of an infection.</p>

<p><b>Standard 3.3: Policies and procedures</b></p> <p>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.</p>	<p>FA</p>	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the IPC programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICN. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p>
<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented on the resident's short-term care plan. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p>

		<p>The ICN and care co-ordinator review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handovers. Surveillance data is entered in the organisation's infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers should it be required. Policy states the use of enablers is voluntary and the least restrictive option. The quality/facility manager is the current nominated restraint coordinator and would provide support and oversight for enabler and restraint management in the facility, should it be required.</p> <p>On the day of audit, no residents were using restraints or enablers. The facility is restraint free and the proposed new owner wishes to maintain this status.</p> <p>Staff education related to safe restraint use and de-escalation management of challenging behaviour is presented to staff annually and last occurred in February 2017. Staff verbalised their understanding of safe restraint use and confirmed the facility is restraint free.</p>

## Specific results for criterion where corrective actions are required

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)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Observations and interviews verified the care provided to residents was consistent with their needs and goals as verified by staff, residents, a family member, the GP and the community mental health nurse. However, in the five of five files reviewed, this was not always evident in the documentation (refer 1.3.3).</p> <p>Two residents with challenging behaviour had no documentation in the care plan detailing the challenging behaviour, the triggers to the behaviour and strategies to manage the behaviour. There was no mention of regular specialist visits and input, and the accessibility of this service if required however interview with the visiting community mental health nurse described the service as “one of the best in the area” for meeting the diverse needs of these residents. She explained that care staff picked up on early warning signs of residents becoming unwell or not functioning too well. Early interventions enabled prompt</p>	<p>The documented interventions in the residents' care plans, is not always consistent with their assessed needs or desired outcomes.</p>	<p>Provide evidence that the interventions documented in the care plan are consistent with residents' needs.</p> <p>90 days</p>

		<p>action to de-escalate potential situations. She felt the environment was always settled, warm and friendly. In addition to this one of those residents mentioned had a history of seizures, and there was no documentation in the care plan in regard to management, monitoring and frequency of these events.</p> <p>In addition to the resident referred to (1.3.3) a resident who cannot weight bear has not been weighed since January and has no documented management plan to monitor and manage any loss. Interviews with staff, verbalised they “can tell by the fit of the resident’s clothing”. No documented PIPM plan is sighted in the care plan, despite the resident having had a PI previously.</p> <p>A resident with history of heart failure, had no documented interventions around the required management to monitor potential deterioration. A recent acute episode is evidenced to be managed appropriately in the progress notes, however there is no short-term care plan implemented detailing acute management strategies.</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 of this audit.

No data to display
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End of the report.