

# The Rest Homes Limited - Makoha Rest Home

---

## 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 HealthShare 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>	The Rest Homes Limited
<b>Premises audited:</b>	Makoha Rest Home
<b>Services audited:</b>	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services – Sensory
<b>Dates of audit:</b>	Start date: 24 January 2018      End date: 25 January 2018
<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>	26



# Executive summary of the audit

---

## 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

Indicator	Description	Definition
Yellow	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
Red	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

This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. Makoha Rest Home can provide care for up to 34 residents with an occupancy of 26 on the day of audit.

The audit process included the review of policies, procedures; residents and staff files, observations and interviews with residents, family, management, a general practitioner and staff;

The facility manager is responsible for the overall management of the facility with an acting clinical nurse manager providing clinical oversight.

Improvements are required to documentation of resolution of issues; resident signing and dating of some forms; initial assessment by a general practitioner; care planning; evaluation of activity plans and smoking areas for residents.

## 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.	Green	Standards applicable to this service fully attained.
--	-------	--

Staff have knowledge and understanding of the rights of residents and consumer rights legislation. Services are provided in a manner that includes residents' rights. The privacy of residents is respected. Residents who identify as Māori have their needs met. The individual values and beliefs of residents are documented and respected by staff. Staff communicate effectively with residents and their families and friends. Staff have a policy that is implemented around open disclosure. Consent is sought verbally and in writing from residents where appropriate. Residents have access to advocacy services. Staff encourage residents to maintain links with their family/whanau and community. The complaints policy is implemented with an up to date register of complaints in place.

## 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.
---	--	---

There is a documented philosophy, organisational plans and a quality and risk and management programme implemented. There are policies, procedures and associated forms with a document control process in place. There is an established system of adverse event reporting and the facility manager understands statutory and contractual reporting requirements. All aspects of the quality programme are monitored with documentation of corrective action plans when issues arise.

The facility manager provides administrative support and support for residents to access the community. The acting clinical nurse manager provides clinical oversight of the service.

Human resource management processes for staff are in place. Staff records reviewed demonstrate evidence of accepted human resource practices. Staffing levels meet the minimum requirements specified in the contract for aged residential care. Staff are able to provide support for residents to meet individual needs. Resident information is managed confidentially.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

Each stage of service provision is developed with resident input and coordinated to promote continuity of service delivery. The residents confirm their input into care planning.

Each resident is assessed with a current interRAI assessment completed. The assessment underpins the documentation of a care plan that includes a broad set of interventions as per individual needs with these reviewed six monthly. Care plans are updated as changes occur.

Residents and family confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Staff responsible for medicine management have current medication competencies. Staff administered medications as per policy during the audit with medicines kept in a secure area.

Food, fluid, and nutritional needs of residents are catered for with additional dietary requirements provided as required.

## 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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

All building and plant comply with legislation with a current building warrant of fitness and New Zealand Fire Service evacuation scheme in place. A maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Outdoor areas are available and accessible to residents. Smoking areas are designated.

Waste and hazardous substances are managed appropriately. The rooms' sizes are adequate to meet the needs of residents and there are communal areas for dining, recreation and relaxation. Cleaning and laundry services are performed onsite.

The building has plenty of natural light, safe ventilation and heating systems to ensure the temperature is maintained within a comfortable range for residents. Emergency systems are in place and these can be activated if required.

## 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.		Standards applicable to this service fully attained.
---	--	--

The restraint minimisation programme defines the use of restraints and enablers. The restraint register is current. Policies and procedures comply with the standard for restraint minimisation and safe practice. Assessment, documentation and monitoring of care and reviews are recorded and implemented. Restraint risks are identified. Staff members receive annual training regarding restraint use.

## 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.

Standards applicable to this service fully attained.

The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. Staff education in infection prevention and control is conducted according to the education and training programme and recorded in staff files. The infection control coordinator has had training around infection control in the past. The surveillance data is collected monthly for review and discussion at clinical meetings. Appropriate interventions are in place to address infections.

## 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)
<b>Standards</b>	0	45	0	4	1	0	0
<b>Criteria</b>	0	96	0	4	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Staff receive training in the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights' (i.e., the Code) at orientation and as part of the annual training programme. Interviews with staff confirm they have a clear understanding of resident rights.</p> <p>The care staff were observed interacting respectfully and communicating appropriately with residents. Residents are encouraged to make choices and all residents interviewed confirmed that this was a strength of the service. Residents interviewed were able to verify that their rights are upheld by staff.</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>There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. Staff use verbal consents as part of daily service delivery. Staff interviewed demonstrate an understanding of informed consent processes. Residents confirm that consent issues are discussed with them on admission and appropriate forms are shown to them at this time and thereafter as relevant. All residents' files reviewed included written consent.</p> <p>All residents have the choice to make an advance directive with these documented by</p>

		residents deemed competent to complete these.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There are appropriate policies in place and brochures on display regarding advocacy support services. Residents interviewed confirm that advocacy support is available to them if required. Staff interviewed understand how residents can access advocacy support persons.
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	Residents have access to visitors of their choice at any time of the day and evening. They are supported to access services within the community and to maintain their links with family and friends. There were a number of visitors calling into the service on the days of audit.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service operates a consumer complaints process that references Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The service has an up-to-date complaints register which identifies the date of the complaint, the complainant, description of the issue and the actions taken.  Consumer complaints received since the previous audit were sampled. A review of two complaints indicate that these are signed off with timeframes met for response and resolution as per policy. The acting clinical nurse manager and facility manager confirm that there have been no complaints made to external authorities since the last audit.  Residents and family interviewed confirm they have had the complaints procedure explained to them and they understand and know how to make a complaint if required. Staff are aware of their responsibility to record and report any consumer complaints they may receive.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family members have open access to talk to the management and staff at any time. Residents and family interviewed confirmed that there is an open-door policy implemented that allows them to talk at any time with managers, registered nurses or other.  Residents interviewed confirm that they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service in the facility's admission

		<p>package prior to the resident's admission.</p> <p>Information on the Code and the Nationwide Health and Disability Advocacy Service are displayed at the entrance to the facility. Residents interviewed confirm they have access to an independent advocate if needed.</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>Staff interviewed are aware of the need to respect the privacy of residents and to respect their belongings. Needs and values of residents are documented.</p> <p>Residents were observed being treated with respect by staff during the audit and the practice was confirmed during interviews of residents.</p> <p>Staff were observed keeping doors closed while attending to residents. Activities in the community are encouraged. Staff and/or family will transport residents to appointments. There was no evidence of any abuse and neglect sighted with staff and the general practitioner confirming that there have not been any incidents of abuse or neglect to their knowledge. Training is provided annually for staff around abuse and neglect.</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 service has a cultural safety policy in place. The policy includes guidelines for the provision of culturally safe services for Māori residents. It includes information on cultural awareness, cultural safety, and the importance of whanau.</p> <p>There are residents in the facility who identify as Māori. There is a specific assessment tool that is used to identify special needs for Māori residents with cultural preferences addressed in plans of care.</p> <p>Access to Māori support and advocacy services is available from the Nationwide Health and Disability Advocacy Services.</p> <p>Staff interviewed confirm an understanding of cultural safety in relation to care. There are staff who identify as Māori and they can speak te reo if required. There is a strong belief in a family atmosphere as described by staff, family and residents interviewed.</p> <p>Staff education on cultural safety occurs annually.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	FA	<p>Culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Residents interviewed confirm their</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>culture, values and beliefs are being respected, and their spiritual needs are being met. Staff interviewed confirmed an understanding of cultural safety in relation to care.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Expected staff practices are specified in their employment agreements and job descriptions. Residents interviewed report that staff maintain appropriate professional boundaries. Staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes. There are policies in place to guide staff practice.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Systems are in place to promote good practice by staff to ensure residents receive services of an appropriate standard of care. The acting clinical nurse manager is committed to ensuring that service provision is based on best practice including access to clinical nurse specialists and District Health Board specialists. The policies in use include references to evidence-based research. References to additional documents are included in policies as appropriate. Training is provided as per the annual training calendar to ensure that staff remain knowledgeable.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is provided. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in accident/incident forms reviewed.</p> <p>Family contact is recorded in residents' records on the family communications record. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to participate in the entry process for their family member and in ongoing care options.</p> <p>Interpreting services are available from the DHB. There are no residents requiring the use of interpreting services although staff do speak in Māori to residents when required. The admission agreement and service information are available in large print and this can be read to residents.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. All admission agreements sampled were signed on the day of admission.</p>

<p><b>Standard 1.2.1: Governance</b></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>Makoha Rest Home and Hospital provides rest home and hospital level care for up to 34 residents. On the days of audit there were 26 residents including nine residents requiring hospital level care (including two funded by ACC and one resident using respite services at hospital level of care) and 15 requiring rest home level care (including two funded by ACC). There are two boarders. There are no resident identified as having sensory disabilities.</p> <p>There is a business risk assessment and management plan in place which includes the quality plan. It contains the purpose, values, scope, and direction. The goals of the organisation are identified and the plan includes objectives and who is responsible. The plan is reviewed by the managers including the director at least quarterly</p> <p>The acting clinical nurse manager has had five years' experience in aged care service, is a registered nurse and has a Master of Teaching and a Post Graduate Certificate in Speciality Care. The previous clinical nurse manager has recently resigned, and the position is being advertised. The facility manager has been in the role since September 2015. The facilities manager provides support with administration; oversight of contracts and registration of residents. The facility manager has a Bachelor of Engineering and is a member of New Zealand Institute of Management. A psychiatrist is identified as the director with all three having input into the management and leadership of the service.</p> <p>The managers and director have documented authority, accountability, and responsibility for the provision of services.</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>	<p>FA</p>	<p>There are systems in place to ensure the day-to-day operation of the service continues if the facility manager is absent. In this situation the facility manager's role is managed by the director who attends management meetings monthly with support from the acting nurse manager. There are senior registered nurses who can provide clinical oversight in the absence of the acting clinical nurse manager if they not available.</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</p>	<p>PA Low</p>	<p>The business operates a quality risk and management system which includes a range of policies, procedures and associated forms. The quality and risk management system includes resident satisfaction with clinical care and environmental systems and processes, internal audit, human resource management, adverse event management, health and</p>

<p>management system that reflects continuous quality improvement principles.</p>		<p>safety, restraint minimisation practices and infection prevention and control systems.</p> <p>There are policies and procedures in place that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals by an external consultant. The policies include reference to interRAI assessments and care planning and the Health and Safety at Work Act. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures are accessible by staff.</p> <p>Key components of service delivery are linked to the quality management system. The quality and risk management system is linked with the health and safety, complaints management and infection prevention and control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of service delivery. Data is collated and analysed with discussion at regular meetings. These include monthly management; registered nurse; staff and restraint meetings.</p> <p>Corrective action plans are developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process and the management meeting. Corrective action plans are documented with an improvement required to the documentation of resolution of corrective actions.</p> <p>Actual and potential risks are identified, documented and appropriately communicated to residents, their family of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted included the identified risks, how these are monitored, if the risk is a significant risk and if the implemented actions can isolate, eliminate or minimise the risk.</p>
<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>	<p>FA</p>	<p>The service has clearly documented and known processes for reporting, recording, investigating and reviewing adverse events. A review of incident/accident records and analysis confirms that all events are reported, recorded and reviewed by the acting clinical nurse manager, as soon as possible. The staff are aware of the need to complete vital signs if there is an unwitnessed fall or head injury. A monthly record is retained of all incidents with these discussed at the staff meetings.</p> <p>The acting clinical nurse manager understands the responsibilities for essential notification to the relevant authorities. The service has not had to report any adverse events to</p>

		external agencies.
<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 policies describe good employment practices that meet the requirements of legislation. A sample of employee records confirmed that each employee has an employment agreement in place signed by the employer and the employee; an application form; evidence of criminal vetting for staff who have been employed in the last two years; letter of offer and a curriculum vitae. A copy of completed orientation and other external training is kept on file. Performance appraisals are completed for staff on an annual basis.</p> <p>Professional qualifications are validated by the acting clinical nurse manager, including evidence of registration and scope of practice for registered health practitioners. This includes annual practicing certificates for the pharmacist; general practitioner, director/psychiatrist and the physiotherapist. New staff receive an orientation/induction programme that covers the essential components of the service provided.</p> <p>All registered nurses including the acting clinical nurse manager are trained in interRAI. A review of attendance records retained align with the annual training plan and confirm that the training provided meets requirements of the District Health Board contract. Staff state that the training is relevant to their needs and requirements professional registration.</p> <p>The director of the service is a psychiatrist with qualifications in public health, management and others. The director provides leadership and clinical advice for the staff in mental health service and in management of residents with acquired brain injury.</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>There are documented and implemented processes that determine staffing levels and skill mix to provide safe service delivery. Staffing considers the layout of the service. The acting clinical nurse manager is onsite five days a week, Monday to Friday. There is at least one registered nurse on duty at all times and one or more caregivers on duty. Staffing is adjusted to meet resident needs</p> <p>The acting clinical nurse manager is on call at all times with a registered nurse rostered to answer any questions with these escalated if need be. The care staffing levels for the service meet the requirements as specified in the District Health Board agreement.</p> <p>Additional staff include the cleaner and cooks with maintenance completed by the facility manager. A physiotherapist is employed for two or more hours a week. There is a diversional therapist contracted to support the service. The director (psychiatrist) is</p>

		<p>available to provide advice if required.</p> <p>A review of the rosters for the past three months confirms that staff are replaced when absent. There is also a staff member on each duty with a first aid certificate.</p> <p>The residents and the relatives interviewed reported satisfaction with the knowledge and skills of the staff and with the care provided.</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>	PA Low	<p>Resident information is entered in an accurate and timely manner into an electronic register. Records are both electronic and paper-based. The master record is paper-based. InterRAI information is recorded accurately in the interRAI software programme. The registered nurses and/or the acting clinical nurse manager enter resident's data into an electronic spreadsheet on the day of admission to the facility.</p> <p>Residents' information is held securely. Information is not on public display.</p> <p>Records reviewed are legible. Historical records are held on site and accessible. An improvement is required to dating and signing of entries into the resident record.</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>Entry and assessment processes are recorded. Information is communicated to residents, family, relevant agencies and staff. The admission agreement defines the scope of the service and includes all contractual requirements.</p> <p>Residents confirm the admission process is completed in timely manner with family engaged in the admission process when at all possible noting that there are few family members engaged with residents in the service. Each resident interviewed states that they are orientated to the site and introduced to other residents and staff on the first day.</p> <p>All resident records reviewed have a needs assessment completed prior to admission to the facility. Admission agreements are completed on admission.</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>There is appropriate communication between families and other providers that demonstrates that transition, exit, discharge or transfer plans are communicated, when required. The residents' files evidence appropriate records relating to risk of transfers where this is required.</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>Medication is stored securely with medicines stored in original dispensed packs. Weekly checks and six monthly physical stock takes occur.</p> <p>The registered nurse was observed to give medication to residents and to sign at the time the medication is administered. The administration sheet is signed by two staff when a controlled drug is administered. Drop/sprays such as eye drops, or nasal sprays are dated when opened. The temperature of the refrigerator used to keep medicines in is monitored daily and in the recommended range.</p> <p>Current medication competencies for staff who administer medicines are current and completed annually. This includes medication competencies for health care assistants who countersign for administration of medications. Administration records are maintained, as are specimen signatures.</p> <p>Medication audits have been conducted and corrective actions are implemented following the audits. There are currently no residents self-administering medicines however processes are in place should these be required with staff able to describe these. A resident can store their medicines in their room and all rooms are locked when the resident is not in the room should they self-administer medication.</p> <p>The pharmacist completes a review of medication six monthly. Stocktakes are completed weekly for controlled drugs. Controlled medication is stored and administered as per policy. A check of the balance of controlled drugs on the day of audit indicates that these are accurate.</p> <p>The medication files reviewed indicate that the general practitioner reviews the medications as directed and at least three monthly. As required medication is prescribed correctly with indications for use documented and maximum dose documented.</p> <p>The medication policy, system and procedures comply with the aged care residential medication guidelines and current legislation.</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>	<p>FA</p>	<p>Kitchen staff have completed food safety training and cook all meals. The cook is aware of the residents' individual dietary needs and nutritional profiles are kept in the kitchen. These are updated on a six-monthly basis or as changes occur and the cooks put any changes on the white board as residents identify food they dislike.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents state they are satisfied with the food service and reported their</p>

		<p>individual preferences are met and adequate food and fluids are provided.</p> <p>The kitchen environment is clean, well-lit and uncluttered. Fridge, chiller and freezer temperatures are monitored regularly and recorded, as are food temperatures with these within normal range.</p> <p>There is a seasonal menu, last reviewed by a dietitian in August 2015. The service has had input from a nutritionist into review of the menu in 2017. Review of residents' files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as special diets, pureed meals along with alternative nutrition appropriate to the residents are available.</p> <p>There is enough stock to last in an emergency for three days for all residents.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</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>There is a process to inform residents and family, in an appropriate manner, of the reasons why the service has been declined. The residents would be declined entry if not within the scope of the service or if a bed was not available. The acting clinical nurse manager acting or registered nurse communicates with the needs assessment service when any issues arise. There have not been any declined entries since the last audit.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The service has processes in place to seek information from a range of sources, for example; family (if engaged in the service); the general practitioner; specialists and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.</p> <p>There was evidence of residents' discharge/transfer information from the district health board where required. The facility has appropriate resources and equipment as confirmed through staff interviews and observation of the environment.</p> <p>Assessments are conducted in a private setting with residents seen in the rooms. Residents confirm their involvement in assessments, care planning, review, treatment and evaluations of care. Staff interviewed can identify needs of residents as per the assessments completed.</p> <p>InterRAI assessments are being documented with all residents having an interRAI assessment on file. Specialised assessments are completed at six monthly intervals and as required. Assessments form the basis of care planning.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Each resident has an initial care plan and long-term care plan completed in a timely manner with these reviewed six monthly. Residents' care plans are individualised. Care plan interventions at times reflect the level of care required however an improvement is required to ensure that there is sufficient detail in the care plan to guide care.</p> <p>Staff report they receive adequate information for continuity of residents' care. The residents have input into their care planning and review.</p> <p>Resident files reviewed include detailed plans around specific issues when these were identified for example around management of challenging behaviours and support required for activities of daily living. There is evidence of specialist involvement where this is required. Any recommendations made by visiting health professionals such as the mental health service staff are included in the individual resident's plan. Requests from the general practitioner are included in the care plan with the general practitioner stating that any directions are followed up well.</p> <p>Short term care plans are documented for short term needs such as infections and challenging behaviours if these are out of the ordinary.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents receive adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions are documented for each goal in the long-term care plans. Interventions are documented when specific needs are identified, for example, around pain management.</p> <p>The general practitioner interviewed confirmed that clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long-term care plan as per individual need. Behavioural management plans are documented with strategies to manage individual behaviours for a resident if required.</p> <p>Care staff document progress notes at the end of each shift or in real time and observation charts are maintained. Staff confirm they are familiar with the current interventions of the resident they are allocated.</p> <p>Short-term care plans are used to document short term episodes that arise for residents (refer 1.3.5). These include short term cares for infections, wounds and other short-term problems. Evidence of resolution of the issue is documented.</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 service contracts a diversional therapist (DT) for four hours a week. They are on site two times a week. There is a volunteer who works for four hours a week. The facility manager takes residents to appointments, outings and shopping during the week. Staff are actively engaged in supporting each resident to engage in activities. One staff member for example is engaged on the executive of the Rotorua Multicultural Council. They bring members to the Council to engage with residents.</p> <p>The activities programme is available to all residents in the rest home and the hospital with some group activities provided to young people under the age of 65 years. The programme is very individualised as there is active encouragement of residents to remain engaged in activities that meet their needs in the wider community. One young person for example has been encouraged to complete training through a tertiary provider and the resident states that this has improved their self-confidence and their ability to engage with others. Two older residents remain actively engaged, for example, with kapa haka groups and other related activities.</p> <p>The group programme is documented monthly and displayed in the dining area. The activities programme includes a range of activities such as outings and cognitive activities and supports celebrations for residents. The activities programme includes a sufficient range of activities for young people under the age of 65 years and for those who do not wish to engage in the group programme. Each resident also has an individualised activity plan. The attendance records are kept in the staff room so that all staff can document resident attendance at activities. The acting clinical nurse manager is coordinating the review of the activities plans to occur in line with completion of interRAI assessments.</p> <p>There is a focus on providing activities that meet the cultural needs of residents. There are a staff employed who identify as Indian, Māori, Philippino, Zimbabwean, New Zealander and Japanese. Each can speak to residents if they identify English as a second or less preferred language.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Timeframes in relation to care planning evaluations are documented in policy and adhered to. In interviews, residents and family confirm their participation in care plan evaluations.</p> <p>Care plans are updated as changes occur for the resident. The residents' progress records are entered on each shift with the registered nurse documenting in the progress notes at least within 24 hours for residents requiring rest home level care and at each shift for those requiring hospital level care. When resident's progress is different than expected, the registered nurse contacts the general practitioner as required with the general practitioner</p>

		<p>interviewed confirming that staff notify them as soon as changes in a resident's condition has occurred.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</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>	FA	<p>Appropriate processes are in place to provide choices for residents in accessing or referring to other health and/or disability services. Residents' progress notes confirm that relevant processes are implemented with appropriate referrals made.</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>	FA	<p>There are documented processes for the management of waste and hazardous substances in place. Policies and procedures provide guidance for staff. Material safety data sheets are available. Staff receive training and education on safe and appropriate handling of waste and hazardous substances, including chemical safety.</p> <p>Facilities are available for the disposal of waste and hazardous substances.</p> <p>Protective clothing is available for staff to use (e.g., gloves and aprons).</p>
<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>	PA Low	<p>The building warrant of fitness expires 24 May 2018. There has been no reconfiguration of the building since the previous audit. There have been no changes to the fire evacuation plan and fire drills are conducted six monthly and as required.</p> <p>All rooms are of sufficient size to accommodate residents and their activities. Equipment has been tested and tagged within the last year and all medical equipment has been calibrated within the last year.</p> <p>The service has a planned and reactionary maintenance programme that is well implemented to maintain the building.</p> <p>There are indoor and outdoor areas that enable residents to complete activities and to safely access and navigate through the building. An improvement is required to review of implementation of smokefree strategies.</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>	<p>FA</p>	<p>There are an adequate number of communal toilets and showers available throughout the facility, which are near the rooms used by residents. There is a separate toilet for use by staff and visitors. Some rooms have ensuite facilities that can accommodate equipment for residents requiring this.</p> <p>The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned.</p>
<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>	<p>FA</p>	<p>Bedrooms are designed for single accommodation. Bedrooms provide adequate personal space to move around within the room safely with larger rooms for those who require this. Resident's bedrooms are personalised by the individual resident. Bedrooms are also designed to accommodate activities for residents who stay for longer periods in their rooms.</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>	<p>FA</p>	<p>There is room for entertainment, relaxation and dining in the service and there are external areas available. Residents were observed moving freely within these areas.</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>	<p>FA</p>	<p>Cleaning policy and procedures and laundry policy and procedures are available.</p> <p>Laundry is performed by staff with all linen washed on site in the laundry. There is a clean and dirty flow in place in the laundry.</p> <p>Chemicals are purchased and stored in the cupboard, which is locked when not in use.</p> <p>The effectiveness of the cleaning and laundry services is monitored on an ongoing basis by the facility manager and acting clinical nurse manager and is included in the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely</p>	<p>FA</p>	<p>The fire evacuation scheme was sighted and confirms approval from the New Zealand Fire Service.</p>

<p>response during emergency and security situations.</p>		<p>Documented policies are in place for emergency management. All registered nurses and care staff are required to complete first aid training. All staff records reviewed included evidence of current skills in the provision of first aid including resuscitation.</p> <p>Emergency and security education is provided to staff during their orientation phase and during refresher training. Staff interviewed confirm recent education on fire management. Staff records sampled provides evidence of attendance at fire safety training. Processes are in place to meet the requirements for emergency management and there is a policy in place. Fire exits are clearly indicated.</p> <p>There is emergency equipment available. The service has emergency torches, a telephone connected to a landline, a first aid kit, radio, blankets, and carries extra food supplies. The site uses electricity and there is a BBQ on site with full gas bottles.</p> <p>The facility carries water for use in an emergency if the water supply was disrupted. This is adequate to support residents and staff for three days in the event of an emergency.</p> <p>The call bell system is operational and a check on the day of call bells confirmed that all are active. The facility manager checks as part of the internal audit programme to ensure that it remains operational. Staff lock the external home doors in the late evenings to ensure that the service is kept safe.</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>	<p>FA</p>	<p>All designated areas used by residents have an external window for natural light. Ventilation is provided by opening windows and doors. The facility uses electricity for heating.</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>	<p>FA</p>	<p>Infection control (IC) policies and procedures provide information and resources to inform staff on infection prevention and control. This includes guidelines around hand hygiene and standard precautions. The delegation of oversight of the infection control programme is documented in policies and procedures. The infection control coordinator (ICC) is the acting clinical nurse manager</p> <p>There is evidence that the staff meetings include discussion of the infection control programme and in particular of any resident issues and surveillance.</p> <p>The IC programme has been reviewed annually with this completed in 2017.</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 ICC has access to relevant and current information which is appropriate to the size and complexity of the service, including the infection control manual; internet; access to experts and education that the registered nurse completes at least annually.</p> <p>The staff meeting includes discussion of infection control.</p> <p>The interview with the ICC confirms awareness of their responsibilities of the position. The visual inspection evidences that there are resources such as paper towels and flowing soap provided.</p>
<p>Standard 3.3: Policies and procedures</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>	FA	<p>The IC policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user-friendly format by an external consultant and contain an appropriate level of information. Policies are readily accessible to all personnel as confirmed at staff interviews. The IC policies and procedures are developed and reviewed as changes occur by an external provider. IC policies and procedures identify links to other documentation in the facility.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control education is provided to all staff, as part of their orientation and as part of the on-going in-service education programme. Staff state that care staff identify situations where IC education is required for a resident such as hand hygiene; cough etiquette and one on one education is conducted.</p> <p>Education sessions are documented with a record of staff attendance maintained. The last training for staff around IC has been provided in 2017. The ICC has completed IC education relevant to their position on an annual basis through the district health board.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the</p>	FA	<p>Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators in the policy. Residents with infections have short term care plans completed to ensure effective management and monitoring of infections. Data around infections and discussion is expected to be reported at monthly care staff meetings with documentation in meeting minutes confirming that this occurs.</p>

infection control programme.		<p>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. Infection summary logs are maintained for infection events in individual resident's files reviewed. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the registered nurses, verbal handovers and progress notes. This was confirmed also through observation of a handover.</p> <p>The clinical manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated monthly. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.</p> <p>Infections are investigated, and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the infection control meeting.</p> <p>When infections were sighted as occurring in files reviewed, these were checked in surveillance data. All were recorded, and data used to review outcomes both for the individual and the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. Enabler use is documented in resident care plans as confirmed for one resident. With three residents in total using enablers. The service has one resident using restraint (bed rail) in use on the day of audit.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure),</p>	FA	<p>The facility maintains a process for determining approval of all types of restraints used. The restraint coordinator completes a restraint assessment, which is then discussed with the general practitioner and family prior to commencement of any restraints. The restraint committee is defined in the restraint minimisation and safety policies and procedures.</p> <p>The duration of each restraint is documented in the restraint plans of residents. Care staff</p>

duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		are responsible for monitoring and completing restraint forms when the restraints are in use. Evidence of on-going education regarding restraint and challenging behaviour is documented. Staff members are made aware of the residents using restraints during monthly staff meetings and at handover as observed on the day of audit. This was confirmed during staff interviews.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessments include restraint related risks. The service records underlying causes for behaviour that requires restraint with a focus on culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. Restraint risks and monitoring timeframes are identified in the restraint assessment records.  A file reviewed for a resident who used restraint confirmed that a comprehensive assessment was completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Before resorting to the use of restraint, the restraint coordinator tries other means to prevent the resident from incurring injury. Restraint consents are signed by the general practitioner, family and the restraint coordinator. Restraints are incorporated in the long-term care plans and reviewed three monthly. The restraint register is up to date.  Files were reviewed where the resident was using restraint (bedrail). They had documentation of risks around restraint and safe ways for the restraint to be used.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint is still required. The family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. Restraint minimisation and safe practices are reviewed.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The facility demonstrates the monitoring and quality review of their use of restraints. The audit schedule was sighted and included restraint minimisation reviews. There are corrective actions put in place when issues are identified. The content of the internal audits includes the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff knowledge and good practice was also included in the quality

		reviews.
--	--	----------

## 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 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	The service has implemented the quality and risk management programme. Issues or service gaps are identified through review of incidents, accidents, complaints, surveillance of infections, implementation of an internal audit schedule, surveys, external review of documentation such as the menu review and discussion of issues through the meetings held with varying stakeholders. At times there is insufficient documentation of resolution of issues although staff can state how issues and gaps were addressed. A review of the environment and other documentation also confirmed that most issues were resolved.	Documentation does not always include evidence of resolution of issues.	<p>Ensure that there is documentation of resolution of issues.</p> <p>180 days</p>
<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the</p>	PA Low	Anyone entering information into the resident record is required to document the date of the entry, name and designation of the recorder and the signature of the recorder. At times aspects of documentation is missing. This is particularly evident on the caregiver plan for wardrobes and on documentation from some visiting health professionals.	Not all entries in a resident record include the date of the entry, name and designation of the recorder and the	Ensure that the date of the entry, name and designation of the recorder and

service provider is identifiable.			signature of the recorder.	the signature of the recorder is documented against each entry in the resident record.  180 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 Low	The general practitioner is required to review a resident within 48 hours of entry of the resident to the service. This is not completed in a timely manner in some instances. The acting clinical nurse manager is actively discussing the issue with general practitioners concerned.	The general practitioner does not always see the resident in a timely manner when initially entering the service.	Ensure that the initial medical review of a new resident is completed in a timely manner.  180 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Care plans are documented in a timely manner. Care plans do not always contain sufficient detail to reflect current cares for example when issues are identified through a medical review or for management of ongoing symptoms. Some examples of lack of documentation in resident records reviewed include lack of documentation of strategies to manage bad oral health; clear strategies to support management of hyper or hypoglycaemia; detailed management of a hand splint.	At times, there is insufficient documentation of strategies and/or interventions in the care plan to support achievement of desired outcomes.	Ensure that each care plan includes sufficient detail of strategies or interventions that will support the resident to achieve desired outcomes.  90 days
Criterion 1.4.2.4	PA Low	There are designated areas for residents to smoke. At times there is a smell of smoke that has seeped in from outdoor areas into the inside of	A smell of smoke was detected at the	Review the smokefree

<p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>		<p>the building. Some staff and residents state that there is a smell of second hand smoke in the service at times. Staff are actively working with residents to manage their smoking and to support them to consider alternatives to smoking. They actively monitor the facility to ensure that residents are smoking in designated areas and that the smell of smoke does not invade into the inside of the facility.</p>	<p>entrance of the room adjacent to the designated smoking deck with some staff and residents interviewed stating that they could smell smoke in the facility in this area at certain times.</p>	<p>strategies currently in place and implement actions as a result of the review.</p> <p>180 days</p>
--	--	---	--	---

## Specific results for criterion where a continuous improvement has been recorded

---

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
--------------------

End of the report.