

Oceania Care Company Limited - Lady Allum Rest Home and Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Oceania Care Company Limited
Premises audited:	Lady Allum Rest Home and Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 April 2018 End date: 18 April 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	136

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

General overview of the audit

Lady Allum Rest Home and Village provides rest home and hospital level of care for up to 142 residents. On the day of audit there were 136 residents residing at the facility.

This surveillance audit was conducted against the relevant streamlined Health and Disability Services Standards and the provider's contract with the district health board. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with residents, family, management, general practitioners, clinical and non-clinical staff.

There were no requirements for improvement at the previous certification audit. There is one area identified as requiring improvement at this surveillance audit relating to meeting minute records not being complete.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible at the facility. This information is discussed with residents and their families on admission to the facility. Residents confirmed their rights are being met, staff are respectful of their needs and communication is appropriate.

The service has a documented complaints management system and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Oceania Healthcare Limited is the governing body and is responsible for the services provided at Lady Allum Rest Home and Village. The organisation has documented its scope, direction, goals, values, and mission statement and these are communicated to staff, residents and families.

The quality and risk management system and processes support safe service delivery. Quality and risk management activities and results are shared among staff, residents and family, as appropriate. Systems are in place for monitoring the services provided. The quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status and clinical indicator reports.

The service is overseen by the business and care manager who is supported in their role by three clinical managers and a clinical resource manager. The clinical managers are responsible for the oversight of the clinical services in the facility.

There are human resource policies implemented in relation to recruitment, selection and staff training and development. An in-service education programme is provided for staff.

The service maintains their documented staffing levels and skill mix to ensure contractual requirements are met. Staff are allocated to support residents according to their individual needs.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Registered nurses are responsible for the provision of care and documentation of each stage of service delivery. There is sufficient information gained through the initial care plans, risk assessments including interRAI, discharge summaries from the district health board where applicable, and the person centred care plans to guide staff in the safe delivery of care to residents. The person centred care plans are resident and goal orientated and reviewed every six months or earlier if required. Short-term care plans are in place to manage short-term problems. Allied health input and a team approach were evident in the residents' files reviewed. The general practitioner reviews residents at least three monthly or more frequently if required.

The activities team implement the activity programme to meet the individual needs, preferences and abilities of the residents. Additional activities are provided for younger people with disabilities. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

Medicines management occurs according to documented policies and procedures, in alignment with legislative requirements and implemented using an electronic system. Medications are administered by registered nurses and senior healthcare assistants. Medicines management competencies for staff who administer medicines are current.

Food services are managed by a contracted provider. All meals are prepared on site. The food service meets nutritional requirements and individual dietary needs of the residents. The menu plans have been reviewed by a dietitian at organisational level. All kitchen staff had completed food safety training. Residents interviewed confirmed their satisfaction with the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness. There have been no building modifications since the last audit.

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.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had four residents using restraint and five residents requesting the use of enablers. All enablers are voluntary.

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.
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The type of infection surveillance is appropriate to the size and complexity of the service. One of the clinical managers is the infection control nurse. Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Oceania Healthcare Limited support office. Surveillance records reviewed evidenced infections are followed up when required. There was one outbreak since previous audit which was appropriately managed and reported.

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	15	0	1	0	0	0
Criteria	0	38	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The services' complaints management policy meets Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Complaint forms and the complaint process are accessible to staff, residents and family. Residents and families are advised of the complaints process on admission. Interviews with residents and their families confirmed their knowledge of how to make a complaint. Staff confirmed that they understand and implement the complaints process when required.</p> <p>The business and care manager is responsible for the management of complaints at the facility. The complaint register for 2018 records 6 complaints with complaints investigated, corrective actions identified and implemented whilst maintaining communication with the complainant. Complaints are signed off.</p> <p>There has been one incident where police investigated an unexpected death and this investigation has been closed out. There are no other complaints or investigations by external agencies.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Review of residents' clinical files evidenced timely and open communication with residents and their families. Communication with family members is recorded in the progress notes and on the family communication sheets. Staff and management interviews confirmed family members are kept informed about change in a resident's condition and if adverse events occur. This was evidenced in clinical files reviewed. The families interviewed confirmed they are kept informed of the resident's status, including adverse events.</p>

<p>provide an environment conducive to effective communication.</p>		<p>The resident information pack includes all relevant information including brochures on advocacy and interpreter services.</p> <p>Policies and procedures are in place for accessing interpreter services. There was one resident not able to communicate in English at the time of audit and their family confirmed during interview that they have access to interpreter services.</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>Services are planned to meet the needs of the residents at rest home and hospital levels of care. The service has a documented mission statement, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training.</p> <p>Lady Allum Rest Home and Village is part of Oceania Healthcare Limited with the executive management team providing support to the service. The business and care manager is responsible for the overall management of the service and is supported by three clinical managers (CM) and a clinical resource manager (CRM). The BCM has been in the role at this facility for three months and previously managed another Oceania facility in the same role. There is evidence the BCM has completed training/education relevant to their role. The CMs oversee the clinical services and have all been in their roles for more than three years. The CRM is responsible for ensuring all staff have access to appropriate resources and equipment throughout the service, supporting clinical managers and assisting with training and education of staff. The CRM has been in their role for a year.</p> <p>The service holds additional contracts for young people with physical disabilities (YPD) and there were four residents receiving care under this contract. The organisations' philosophy and strategic plan reflect a person/family centred approach for all residents, including YPDs. There is one resident receiving care under the Accident Compensation Corporation contract.</p> <p>The facility can provide care for up to 143 residents with 136 beds occupied at the audit. This included 39 residents requiring rest home level care and 97 residents requiring hospital level care.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>PA Low</p>	<p>The service uses Oceania Healthcare Limited's quality and risk management framework. The framework is documented to guide practice and to minimise risks to residents, staff and visitors. Key components of service delivery are linked to their quality management system. Quality and risk issues are discussed at facility's meetings. Meeting minutes are recorded but do not consistently reflect persons identified to implement changes, timeframes for implementation or sign-off after implementation of changes.</p> <p>The monthly facility business status report provides the executive management team with progress against identified indicators. Management and staff confirmed quality activities are discussed at regular meetings and they are kept informed of quality improvements. The service implements organisational policies and procedures to support service delivery. All policies and procedures are current, reflect best practice, meet legislative</p>

<p>continuous quality improvement principles.</p>		<p>requirements and are reviewed regularly as defined by policy, including non-acute medical policies. When policies are updated, changed or new policies introduced, these are distributed to staff to read and sign to confirm they have read and understood the new policy. The document control system ensures that obsolete documents are removed from use. Staff stated they are informed of new and revised policies.</p> <p>The service has an internal auditing programme that covers service delivery.</p> <p>The service has a documented health and safety programme, which includes managing hazards, reporting and investigating accidents, planning for emergencies, and health and safety education to ensure staff, visitors and contractors meet the standards. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated.</p> <p>Residents receiving care under the YPD contract confirmed having opportunity to make input into quality improvements, have choices regarding service delivery and contributing to decision making. These residents also confirm they have access to appropriate technology, aids, equipment and services, including external services of their choosing.</p> <p>Resident and family satisfaction surveys are completed annually, collated and the information used to implement changes to the services. The last satisfaction survey was completed in 2017.</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>Management understand their obligations in relation to essential notification including situations in which the service would need to report and notify statutory authorities such as: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks and changes in key clinical managers. The appropriate authorities were notified during a recent Auckland-wide power outage. There have been no other events that have required essential notification.</p> <p>The incident and accident reporting processes are documented and any corrective actions to be taken are shown on the forms used by the service. Corrective action plans to address areas requiring improvement regarding incidents and accidents meet requirements. Management confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated.</p> <p>Staff stated they report and record all incidents and accidents, and this information is shared at all levels of the organisation, including any follow up actions required being reviewed at facility meetings. Residents' files evidenced staff are documenting adverse, unplanned or untoward events on accident/incident forms. The registered nurses undertake assessments of residents following an accident/incident and this is recorded on an accident/incident form and in the resident's clinical file.</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>	<p>FA</p>	<p>Staff that require professional qualifications have them validated as part of the employment process. Annual practising certificates were sighted for all staff and contractors who require it.</p> <p>Written policies and procedures in relation to human resource management are documented. Management stated staff complete an orientation programme that covers the essential components of health and safety and service delivery, with specific competencies for their roles. Completed orientation booklets were sighted in staff files reviewed. Newly appointed staff are police vetted upon employment, referees are checked and job descriptions clearly describe staff responsibilities and best practice standards, as sighted in staff files reviewed. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.</p> <p>Staff undertake training and education related to their appointed roles. The in-service education programme and the core study days were reviewed and evidence education is provided to all staff. The core study days are provided for registered nurses (RN), healthcare assistants and non-clinical staff. The core study days provide mandatory education and training in the required areas relevant to the levels of staff responsibilities and authority. Individual attendance records for each education session were reviewed and evidenced ongoing education is provided. Competency assessment questionnaires are current.</p> <p>Ten of the eighteen RNs, including the CMs, have completed the required interRAI training. Two RNs are currently completing interRAI training and a third RN is scheduled for training.</p> <p>Services are suitable and meeting the needs have residents including appropriate care for YPD residents. Independent living suites are located throughout the hospital and rest home, enabling residents in these units to have suitable access to nursing stations and clinical staff.</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>Oceania Healthcare Limited (Oceania) policies identify staffing levels and skill mix to meet residents' needs and comply with the DHB's contractual requirements and safe staffing guidelines. Documentation reviewed confirmed adequate numbers of suitably qualified staff are on duty to provide safe and quality care. There is a RN on duty every shift and the CMs and the CRM are on call after hours and weekends. The on-call arrangements are known to staff.</p> <p>Residents interviewed stated their needs are met in a timely manner. Staff confirmed there are adequate staff on each shift and they have time to complete tasks to meet residents' needs. Staffing levels and skill mix are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents.</p> <p>Rosters are prepared two weeks in advance in a six week roll-over programme. Residents in the independent living suites have access to nurses' stations, staff and management, with appropriate staffing levels to ensure their care.</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 system and policies and procedures comply with medication legislation and guidelines. Residents' medicines are stored securely. Medication administration practice complies with the medication management policy, as observed on lunchtime medication rounds. Weekly checks and six-monthly stocktakes are conducted and to confirm that stock levels are correct. The medication fridge temperatures are monitored weekly. Eye drops are dated when opened. A system is in place for returning expired or unwanted medications to the pharmacy. There was one resident self-administering medication (packed medicines) in the facility. The resident has been assessed and is reviewed three monthly as competent to do this by the GP. Locked drawers are provided. Standing orders are reviewed annually by the GPs.</p> <p>Registered nurses and HCAs administer medications. Medication competencies are evident for all staff who administer medications. Annual medication education is provided.</p> <p>All medication charts reviewed were legible, up to date and reviewed at least three monthly by the GP. There was photo identification on each medication chart and allergy status was recorded. As required medication had prescribed indications for use.</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>A contracted service provider manages the food service. The five weekly seasonal menu has been reviewed by a dietitian. All meals are prepared on site, transported via hot boxes and served from bain-maries in each of the six different dining rooms. All kitchen staff have completed food safety certificates. The food service was externally audited on the days of audit.</p> <p>The RNs complete residents' dietary profiles on admission and identify the residents' dietary requirements and preferences. The kitchen manager confirmed awareness of individual resident dietary needs and diets are modified as required. The RN communicates any changes in resident needs to the kitchen manager. Residents with identified weight loss problems are provided with supplements.</p> <p>Food services comply with current legislation and guidelines. All food is stored correctly and safely as required. Temperatures of food, refrigerators and freezers are maintained. A regular cleaning scheduled is implemented. Residents and families interviewed confirmed satisfaction with the food service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in</p>	<p>FA</p>	<p>The RNs and healthcare assistants interviewed, inform they follow the PCCP and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g. to the wound nurse specialist). If external medical advice is required, this will be actioned by a GP. Staff have access to sufficient wound supplies and continence products. The residents' care plans are completed by the RN and based on assessed needs, desired outcomes and goals of the residents. Care planning includes</p>

<p>order to meet their assessed needs and desired outcomes.</p>		<p>specific interventions for both long-term and the short-term problems. Wound assessment, monitoring and wound management plans are in place for residents with wounds. Monitoring forms are in use as applicable, such as weight, observations and repositioning.</p> <p>Regular reviews by the GP are evidenced in the residents' files. Staff interviewed confirmed they are knowledgeable about the needs of the residents. Family/whānau records evidence communication is documented and timely. Observation charts and progress notes are documented as required.</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>There is an activity plan that meets the group and individual preferences of the resident group. There are six activities staff including a team leader, two diversional therapists (DT) and three activities coordinators.</p> <p>Each resident has an individual activities assessment on admission. An individual activities plan is developed for each resident by the diversional therapist (DT), in consultation with the RNs. A memory lane booklet provides a profile and life journey for each resident. Evaluations are completed six monthly by the DT at the same time as the PCCP evaluations. Each resident is free to choose whether they wish to participate in group activities. Participation is monitored. There are large printed activities timetables on the residents' noticeboards throughout the facility.</p> <p>There is a wide variety of activities offered. On the day of audit, residents were observed participating in activities. Entertainers visit regularly and special events, including holidays and birthdays are celebrated. Residents can attend activities of interest in the community and the facility provides a weekly van outing. An activities staff member takes residents on individual and group walks outside the facility. Residents who prefer to stay in their room can have one-on-one visits including, for example, reading, hand massage and music. There is a chaplain who holds weekly church services and church visitors come in. An occupational therapist is available and attends activities meetings.</p> <p>The service had young persons with specific care plans including additional social activities and community links to meet their specific needs.</p> <p>There was evidence the activities staff are part of the interRAI evaluation process. The residents and their families reported satisfaction with the activities provided. Resident meetings are conducted bimonthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>The RNs evaluate the PCCP at least six monthly or earlier if there is a change in health status. There are at least three monthly reviews by the GP. All changes in health status were documented and followed up. The RN completing the plan signs care plan reviews which include the degree of achievement towards meeting desired goals and outcomes. Short-term care plans sighted were evaluated and resolved or added to the PCCP if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the</p>

comprehensive and timely manner.		care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building warrant of fitness is current. The BCM stated there have been no alteration to the buildings since last certification audit.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>Infection surveillance is part of the infection control programme and is described in the Oceania Healthcare Limited surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. Review of resident files confirmed short-term care plans are in place for residents with infections. One of the CMs is the infection prevention and control nurse. Surveillance of all infections is entered onto a monthly infection summary by the CM. The CM confirmed strategies continue with staff vigilance in recognising early signs and symptoms of possible infection and early diagnosis and newly implemented treatment options. Review of monthly infection data confirmed numbers of infections remain low for this facility. Interviews with staff confirmed specific training is provided and they receive communication about infections at staff meetings, handovers and documentation in short-term care plans and progress notes.</p> <p>Collated data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at monthly management and staff meetings and are communicated to Oceania support office. If there is an emergent issue, it is acted upon in a timely manner.</p> <p>The CM confirmed that there had been one outbreak of infection at the facility since the last audit. This was reported and managed successfully.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Oceania Healthcare Limited restraint minimisation policies, procedures and safe practice handbook are in place and comply with legislative requirements. The restraint coordinator is the CRN. A signed position description was sighted. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. There were four residents using restraint and five residents using enablers during the on-site audit days. The restraint register is maintained and current. Required documentation relating to restraint is recorded.

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	<p>Regular audits are undertaken and corrective action planning put in place to manage shortfalls identified.</p> <p>The audit team reviewed a variety of meeting minutes during the onsite audit. Meeting minutes are recorded on a template which includes who attended the meeting. Of the fifteen different meeting types occurring at the facility regularly, at least two or three meeting minute records for 2018 were reviewed for each type of meeting. Meeting minutes reviewed evidenced not all meeting minutes record the person responsible for the implementation of changes, timeframes or sign-off after changes have been implemented.</p>	Meeting minutes do not consistently record the person responsible for implementation of changes, timeframes or sign-off when completed.	<p>Meeting minutes to consistently record the person responsible for implementation of changes, timeframes or sign-off when completed.</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.