# Pinehaven Cottage Limited - Pinehaven Cottage

## 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Pinehaven Cottage Limited

**Premises audited:** Pinehaven Cottage

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

**Dates of audit:** Start date: 12 June 2018 End date: 13 June 2018

**Proposed changes to current services (if any):** Reconfiguration of services by the conversion of five rest home beds into the dementia unit. This will increase the dementia unit by five beds from 17 to 22 beds and decrease the rest home rom 17 beds to 12 beds. The secure entrance to the dementia unit will be moved to accommodate this change in stages as rooms become available.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 32

# 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 |
|  | 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

Pinehaven Cottage provides rest home and secure dementia care for up to 34 residents. The service is operated by four owner/directors who are experienced in the aged care industry. Two owner/directors work full time at the facility and share management responsibilities. A registered nurse oversees the clinical services management. Residents and families spoke positively about the care provided.

The service is increasing the number of secure care beds (dementia) from 17 to 22 beds and decreasing the number of rest home beds from 17 to 12. These changes are occurring in stages. At the time of audit, stage one was complete with 18 secure beds available, with 17 occupied. Available rest home level care beds were 16, with 15 occupied. The overall number of beds available remains at 34. The changes to date have not impacted on services. The owner/directors have documented how changes will be managed and their preparedness is evident. Staff confirmed they are kept fully informed and that there has been no impact on their workloads.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family, management, staff, and a general practitioner.

This audit has identified an area requiring improvement relating to overdue interRAI assessments.

## 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. |

Residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident’s needs.

A complaints register is maintained with complaints resolved promptly and effectively.

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

Business and quality and risk management plans include the mission statement, vision and philosophy of the organisation. Monitoring of the services provide the governing body the ability to identify any shortfalls. Experienced and suitably qualified persons manage the facility. The two owner/directors who work at the facility full time are both occupational therapists with one maintaining current registration.

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical and biomedical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating for both the rest home and secure unit residents.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken both onsite for personal clothing and offsite for larger linen items and evaluated for effectiveness.

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

## 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 organisation has implemented policies and procedures that support a restraint free environment. No enablers or restraints were in use at the time of audit. Policy contains appropriate assessment, approval and monitoring processes and show that regular reviews are required should restraint be put in place. Policy identifies enablers as voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| 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 prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

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

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 44 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 0 | 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)** |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Pinehaven Cottage (the Cottage) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented for residents as relevant, in the residents’ records. Residents whom reside in the secure home (dementia unit) had EPOA enacted documents sighted in files reviewed. Staff were observed to gain consent for day to day care. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given information about the Code in the admission agreement, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have 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 are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. There is a main lounge with access to the outside courtyard and two smaller lounges in the secure home. There is one large lounge with fireplace, dining room and access to an outside courtyard in the rest home. Lounge chairs are arranged in these areas to support residents and families with privacy and comfort catering for small and larger groups when visiting other than in the residents’ bedrooms. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Forms are on display at the entrance to the facility.  The complaints register reviewed showed that two complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The owner/directors are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in the main entrance to the Cottage together with information on advocacy services, how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they/their relative receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities and participation in clubs and helping in day to day chores of their choosing. Care plans included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The registered nurse interviewed reported that there is one resident who affiliates with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is no specific current Māori health plan, however there is an initial Maori health assessment that acknowledges all values and beliefs with the support of the Te Whare Tapa Wha model. Information obtained from the assessment was sighted and integrated into the resident’s long-term care plans which included the resident’s values and beliefs around food and fluids, sleep and rest, spiritual and cultural support, communication, hygiene, grooming, oral hygiene, elimination, medical requirements, visiting of friends/whanau, death and dying. There is input from a cultural adviser/kaumatua within the local community who visits the resident monthly. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. The resident was not available for interview, however a whanau member interviewed stated that they were very happy with the care provided. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident’s personal preferences, required interventions, and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, gerontology and wound care nurse specialists, psychogeriatrician, mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.  Other examples of good practice observed during the audit included day to day discussions between staff, residents, family and visitors and the knocking on residents’ doors before staff entered their rooms. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. There was one resident with a significant sensory loss and relevant equipment and resources were in place, for example, staff assist the resident with mobility and activities of daily life all the while providing opportunities to support and encourage independence. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans, which drive the services provided, are reviewed annually, outline the mission statement, vision and philosophy of the organisation, and identify the goals and objectives. The documents describe annual and longer-term objectives and the associated operational plans. A sample of monthly documented reports completed by the owner/directors showed adequate information to monitor performance. Information included occupancy, quality data, staffing, emerging risks and issues.  The service is managed by two of the owner/directors who have owned the facility since 2014. Both are trained occupational therapists and one holds a current practising certificate. Clinical care is overseen by a registered nurse who has many years’ experience in aged care and has worked at the facility since 2016. All before mentioned staff hold relevant qualifications. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements.  The owner/directors confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through attendance at aged care conferences and education, Waitemata District Health Board (WDHB) outreach meetings for age care providers (monthly), and support a close working relationship with local organisations, such as the hospice and Age Concern.  The service holds contracts with WDHB for up to 34 rest home and secure dementia care including respite residents. There were 32 residents at the facility on the days of audit. Thirty-one residents were receiving services under the Age Related Residential Care contract and one resident is under the Long Term Chronic Care contact at the time of audit. |
| Standard 1.2.2: Service Management  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. | FA | As there are four owner/directors they ensure that they are never on leave at the same time. One owner/director is always available to carry out management duties. During absences of key clinical staff, the clinical management is overseen by a casual registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and wound care, pressure injuries, falls and behaviour management.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the continuous quality improvement meetings, general staff meetings, and clinical staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, implementing corrective actions and being actively involved in decision making for any changes to services offered. Relevant corrective actions are developed and implemented to address any shortfalls.  Resident and family satisfaction surveys are completed annually. The most recent survey (April 2018) showed that the responses have been analysed and follow up actions have been undertaken where possible. Examples sighted related to, laundry where one resident felt that clothing stain removal was poor. This has been discussed with caregivers to make them more vigilant regarding personal laundry. One resident was not happy with the food service and stated they were getting food they did not like. Management and kitchen staff interviews and documentation sighted identified that all resident likes and dislikes are catered for. Some residents were not satisfied with the destination of outings. Meeting minutes sighted show that there has been a restructure to the activities plan to help improve outings and to also better capture weekly activity data. Issues raised in the resident satisfaction survey related to medical services are to be addressed in a meeting which is being held with the GP and management later in June 2018.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The owner/directors described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. One example related to a fire exit gate not releasing automatically when the fire alarm was activated. Staff were immediately notified, and an approved fire equipment provider rectified this promptly. One owner/director has undertaken health and safety training and is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and analysed by the owner/directors. Information is shared at staff meetings and follow up action outcomes are discussed. For example, the analysis of incidents identified that staff were not always undertaking neuro-observations following unwitnessed falls. Staff education has occurred and there is a reminder in the staff communication book for this to occur. Another corrective action related to staff not always using the ‘chair raiser’ to assist a resident who has fallen to get up. All staff interviewed are aware of this and confirmed they have read and understand the ‘no lift’ policy.  The owner/directors described essential notification reporting requirements, including for pressure injuries. They advised there had been one level three pressure injury in 2017 which was non-facility acquired, which they did not report; however, the owner/directors confirmed their awareness of this requirement now. A section 31 report was filed with the Ministry of Health in November 2017 related to a resident who absconded. All appropriate actions are recorded including police and family notification.  There have been no police investigations, coroner’s inquests, issues-based audits and any other notifications since the previous audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and then annually.  Continuing education is planned on a biannual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. One owner/director is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. There is one registered nurse trained who maintains their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. (Refer comments in criterion 1.3.3.3). The administrator has management access only for interRAI. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. The service uses the interRAI acuity data reports to ensure staffing ratios meet the needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. A registered nurse works five days a week and an enrolled nurse works five days a week which includes weekends.  With the change to the configuration of services, an additional caregiver has commenced a 5 pm to 9 pm shift. Management confirmed they will increase these hours once all the changes to 22 dementia care beds is completed. There will be no increase in total bed numbers, but management recognise that an increase in staffing hours will assist in keeping all resident centred care services at an optimal level of care. The owner/directors are aware that dedicated staff must be available and in the secure unit (dementia care) at all times.  Activities occur seven days a week, kitchen staff work 8.30am to 2pm and 4pm to 6pm seven days a week, and a dedicated cleaner works 8 am to 2 pm Monday to Friday.  Owner/directors are on site six days a week and on call 24 hours, seven days a week. The administrator works four days a week 8.30 am to 4.30 pm. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC or GP for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Admission agreements showed EPOA had consented for the residents to be admitted to the secure home (dementia unit). Service charges comply with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB’s ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed evidence of the supporting documents provided when the resident was transferred and communication that occurred between the facility and family. Family of the resident interviewed stated that they had been kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries when the cottage had controlled drugs on site.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is recorded on the medicine chart.  There were no residents who were self-administering medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by one of three cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan. A registration certificate was issued with an A grade identifying a 98 % mark and expires 6 April 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants/care staff completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. InterRAI assessments are completed by only one registered nurse trained interRAI assessor on site. Residents and families confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments completed were reflected in care plans reviewed.  Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. Care plans specific to support residents with challenging behaviours including triggers and interventions for behaviours over a 24 hour period were sighed for residents residing in the secure unit (dementia unit). Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is very good. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  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. | FA | The activities programme is provided by three activities co-ordinators and overseen by an occupational therapist. The activities co-ordinators support the residents Monday to Sunday from 11 am to 5.30 pm and meet with the occupational therapist monthly.  A social assessment and history is undertaken on admission by the occupational therapist, who is also the owner/director of the Cottage, to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.  Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive.  Activities for residents from the secure home (dementia unit) are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes day to day discussions and reminiscing, supported walks, craft and day to day household chores of the residents choosing. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change however not all interRAI assessments were up to date (see criterion 1.3.3.3). Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a ‘house doctor’, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to physiotherapy, mental health services for the older adult, a wound clinical nurse specialist and speech language therapist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products. Relevant training is undertaken for staff who handle chemicals. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.  There is provision and availability of protective clothing and equipment and staff were observed using this |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 26 May 2019) is publicly displayed. All work being undertaken is internal and does not change the building footprint.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The staged changes to the rest home and secure unit area have commenced. Currently there are two additional bedrooms forming part of the secure unit and two less rest home level care bedrooms. Going forward the service intends to remodel the laundry and moved so it remains in the rest home area. Three bedrooms which are now rest home level care will become part of the secure unit. When work is completed the service will have a total of 22 secure beds and 12 rest home level care beds. The ongoing changes will occur as soon as this is financially viable. The owner/directors are aware that all building and fire requirements are to be met during and following the remodelling of the area. The remodelling will not change the current total number of bedrooms, which will remain at 34. No additional equipment is required for the reconfiguration of services as all residents are deemed rest home level care.  The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the owner/directors and observation of the environment. The environment was hazard free, residents were safe and independence is promoted.  External areas are safely maintained and are appropriate to the resident groups and setting. Residents have access to internal outdoor courtyards (separate courtyards for rest home and the secure unit residents). There are shaded outdoor areas with appropriate seating.  Residents and family members interviewed were very happy with the environment. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes one bedroom with full ensuite facilities and two bedrooms with toilet only ensuites. Toilet and bathroom areas in the rest home are being renovated to a good standard. The secure unit is a recent addition with modern facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. The bedroom doors are single opening which is adequate for rest home level care.  There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. The dining and lounge areas in both the rest home and the secure unit are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. There is a quiet lounge/library area in the secure unit and a kitchenette from which tea and coffee can be obtained and snack food is kept in the fridge. Furniture is appropriate to the setting and residents’ needs.  The dining and lounge areas in the secure unit are large enough to cater for up to 22 residents. The reconfiguration of services does not affect the dinging or lounge areas of the rest home. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is undertaken in a dedicated laundry on site for residents personal clothing only. This is part of the caregivers’ daily schedule. All bedlinen and larger items of laundry are sent off site to a commercial laundry. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. One resident identified laundry as an issue in the resident survey and this has been addressed by the service. Refer comments in Standard 1.2.3  The cleaners have received appropriate training as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.  Cleaning and laundry processes are monitored through the internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. This includes the secure unit. The current fire evacuation plan was approved by the New Zealand Fire Service on the 24 August 2016 when the new secure unit was built. The owner/directors confirm their knowledge and understanding of ensuring they meet all fire service requirements as part of the reconfiguration. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 13 April 2018; no follow up was required. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ’s were sighted and meet the requirements for the 34 residents. A water storage tank which holds 900 litres of water is located on the grounds and maintenance of water purity is the role of one of the owner/directors. There is a petrol generator on site. Emergency lighting is regularly tested.  Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells. The call bell system is monitored by an off-site provider and can also be used as a nurse alert system for residents who are at high risk of falls.  Appropriate security arrangements are in place. The secure unit has internal secure outdoor areas. Doors and windows are locked at a predetermined time and checked as part of afternoon staff duties. Staff confirmed during interview that if they have any concerns they would dial 111. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating in the secure unit is electric underfloor central heating and in the rest home it is electric wall heaters and a wood burner in the main lounge area. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service implements an infection prevention and control (IPC) programme to minimise the risk of infections to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the GP and gerontology clinical nurse specialist. The infection control programme and manual are reviewed annually.  The registered nurse and enrolled nurse share the role of designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the director/owners and tabled at the quality/risk committee meeting. This committee includes a director-owner, IPC coordinators, and representatives from activities, food services and household management as required.  The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IPC coordinators have appropriate skills, knowledge and qualifications for the role, and have both been in this role since April 2018. They have both undertaken a training in infection prevention and control and attend relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The IPC coordinators have access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinators confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are due to be reviewed in 2018 and include appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinators. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a gastroenteritis outbreak in October 2017.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather. |
| 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 | Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastroenteritis and other infections. The IPC coordinator/registered nurse and enrolled nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff shift handovers.  The Cottage has had a total of 16 infections since October 2017. One resident has been identified with five of those 16 infections due to co-morbidities. The residents’ files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.  A summary report for a gastrointestinal infection outbreak in October was reviewed, where four residents and four staff were affected, and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The service currently has a restraint free environment which was confirmed in the restraint register and staff meeting minutes sighted. The restraint coordinator provides ongoing education to staff to ensure they maintain their knowledge should restraint be required. Staff demonstrated a sound understanding of the organisation’s policies, procedures and practice related to restraint.  Policy clearly identifies that enablers would only be used if requested by residents and that they would be the least restrictive item to allow residents to remain safe.  Restraint would only be used as a last resort when all alternatives have been explored. This was evident from interviews with staff and the owner/directors.  Only residents who are assessed as requiring secure dementia care are in the secure unit. |

# 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)** |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | All residents have individual details and client specific initial care plans and long-term care plans. Residents have an interRAI assessment completed by one trained interRAI assessor on site as the other interRAI trained registered nurse left the home in April 2018. The owner/directors interviewed stated that they will explore the option and availability of a roving interRAI assessor to support the registered nurse to update the interRAI assessments. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment processes. On the day of audit 15 residents did not have an up to date interRAI assessment. | Two residents with interRAI assessments due in February, three residents with assessment due in March and five residents due in both April and May did not have an up to date interRAI assessment. Two of the five residents with assessments due on the 4 April were in draft but had not been commenced until the 10 June 2018 and remained uncompleted. | Provide evidence that all residents have an up to date interRAI assessment.  90 days |

# 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, these 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.