Oceania Care Company Limited - Elderslea Rest Home

Introduction

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

The audit has been conducted by 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:	Elderslea Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 30 April 2019 End date: 1 May 2019
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: 103	

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

Elderslea Rest Home can provide services for up to 124 residents requiring rest home, hospital or dementia level of care. There were 103 residents at the facility on the first day of the audit.

This certification audit was completed to establish compliance with the relevant Health and Disability Services Standards and the facility'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, staff and a general practitioner.

The business and care manager is responsible for the overall management of the facility and is supported by a clinical manager, the regional clinical and quality manager and the executive management team. Service delivery is monitored.

There were no areas identified as requiring improvement.

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.

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 are accessible at the facility. This information is brought to the attention of residents and their families on admission.

Residents and their families confirmed they are informed and have choices relating to the care they receive. Residents and family members confirmed their rights are being met. Staff are respectful of the needs of residents and communication is appropriate.

Policy and procedures relating to the complaints management process comply with the Right 10 of Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

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.

Oceania Healthcare Limited is the governing body responsible for the services provided at Elderslea Rest Home. The scope, direction, goals, values and mission statement of the organisation is displayed within the facility.

The facility implements the Oceania Healthcare Limited quality and risk management system. The quality and risk management plan supports the provision of clinical care and quality improvement at the facility. Policies are reviewed. Business status reports to the national support office are completed monthly.

Business reports include monitoring of service delivery and quality and risk performance. Benchmarking includes clinical indicators, infections, incidents/accidents and complaints. The organisation showed that monitoring of incident and accidents and issues identified in meeting minutes and the internal audit programme are managed through a corrective action process. Risks are identified, monitored and recorded.

The facility is managed by a business and care manager who is supported by a clinical manager. The clinical manager is a registered nurse and is responsible for oversight of clinical services. The management team is supported by the regional clinical quality manager.

Policies and procedures to guide human resource management are in place and implemented. Recruitment and employment practices are aligned with legislative requirements. Registration with professional bodies is verified annually for all staff who require these. A training programme is in place and implemented. In-service education and training is provided for all staff. Mandatory training relating to clinical service delivery occurs. Staff competency is routinely assessed.

Staffing levels are appropriate across the facility. Registered nurses are on duty 24 hours a day, 7 days a week. The registered nurses are assisted by care and support staff. There is always at least one staff member on duty, with a current first aid certificate. The service has an on-call programme in place for support from senior staff, when needed. Rosters showed that staff are replaced when on leave or not able to work.

The service uses an electronic resident information management system with password protections to prevent unauthorised access.

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.

The residents' needs are assessed on admission by registered nurses and the initial care plans are developed. The residents' files reviewed provided evidence of documented residents' needs, goals and outcomes that are reviewed on a regular basis. Short-term care plans for acute conditions are implemented when required. Nursing care plan evaluations are documented, resident-focused and indicate progress towards meeting residents' desired outcomes. The residents and families interviewed reported being informed and involved.

Planned activities are appropriate to the residents' assessed needs and abilities. Participation is encouraged and is voluntary. Residents expressed satisfaction with the activities programme in place. The activities programme includes a range of activities and involvement with wider community. Individual activities are provided either within group settings or on a one-on-one basis. Special consideration is given to younger people with disabilities when planning the activities programme.

Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

There is a medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. There is a central kitchen and on-site staff that provide the food service. Resident interviews 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. |
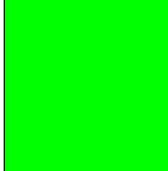
There is a current building warrant of fitness. The service has a planned preventative and reactive maintenance programme in place and complies with legislative requirements. Maintenance programmes include equipment, temperature and electrical checks.

Bathroom and showering facilities are provided throughout the facility and are accessible. The facility has a call-bell system in place used by residents to call for help, when needed. Essential security systems are in place to ensure resident safety. The service completes six monthly trial fire evacuations.

Policies and procedures are documented and implemented for cleaning and waste management. Staff receive training to ensure the safe handling of waste, chemicals and hazardous substances. There was evidence of adequate cleaning, storage, equipment and protective equipment and clothing. The service includes an on-site centralised laundry. Cleaning services are provided seven days a week by household staff and monitored.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The restraint minimisation and safe practice policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use.

There were two residents using restraint and no residents requesting the use of enablers on audit days. Staff education on restraint, de-escalation and challenging behaviour has been provided.

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.
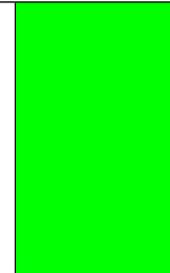
The infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection and cross infection and contain the requirements of the standard. The service provides an environment which minimises the risk of infection to residents, staff and visitors. Infection control education is provided to staff as part of their orientation and as part of the ongoing in-service education programme.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. The results of surveillance are reported through all levels of the organisation, including governance.

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	50	0	0	0	0	0
Criteria	0	101	0	0	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff receive training in the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights' (the Code) at least annually as confirmed in records sighted. Education relating to the Code, including the complaints process, is provided by Health and Disability Advocacy services and as part of grow, educate and motivate (GEM) study days. Staff were able to provide examples on ways the Code is implemented in their everyday practice, which includes residents' privacy and providing choices. Care staff were observed interacting with residents in a respectful and supportive manner. Residents are encouraged to be independent and able to practise their own values and beliefs. Residents and family members verified that services are provided with dignity and respect.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed	FA	The information pack for new residents and their families/whānau includes information regarding informed consent. The business and care manager (BCM) and CM discuss informed consent processes with residents and their families/whānau during the admission process.

choices and give informed consent.		Policy and procedures are in place to guide staff in relation to obtain informed consent, including guidelines for obtaining consent for resuscitation and advance directives. The GPs sign to state the competence of the resident and the resuscitation status discussed with the resident and or their family. Staff ensure that all residents are aware of treatment and interventions planned. Resident and significant others/EPOA are included in the planning of that care. Residents' files identified that informed consent is obtained. Staff confirmed their understanding of informed consent processes.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Policies and procedures are in place to guide advocacy and support for residents who require to access advocates. The role of advocacy services is included in training on the Code which is provided to staff during study days. Information on advocacy services is provided through the Health and Disability Commissioner's Office and made available at the entrance to the service along with nationwide advocacy details. Interviews with families and residents identified that the advocacy support is available to them if required, including information on how to access a Health and Disability advocate.
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	There is an open visiting policy in place and residents may have visitors of their choice at any time. Visitors can access the facility after dark when doors are locked at night, using the call bell and intercom at the entrance to call staff and obtain access. Families confirmed they could visit at any time and are made to feel welcome. Residents interviewed, including YPD, confirmed they are encouraged to be involved in community activities and to maintain networks with family and friends. Residents' files reviewed, and handover observed demonstrated that progress notes and the content of care plans include regular outings and appointments.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and	FA	There is a complaints policy and procedures in place which are in line with the Code, including required periods for responding to a complaint. The BCM is responsible for managing complaints and the complaints register. Complaint forms are available at the entrance of the facility and provided in facility information packs.

upheld.		There have been two complaints since the appointment of the new BCM and two open coroners' investigations. Review of documentation in response to two coroner's investigation showed communication and availability of records. Interviews with the BCM and the regional clinical and quality manager (CQM) confirmed actions taken to ensure the best possible communication with the coroner. These investigations remain open. There have been no other complaints to external agencies since the previous audit.
		The complaints management register contained evidence that complaints are investigated, and issues are resolved in a timely manner. The outcomes of the investigation and identified corrective actions are discussed with the complainants as verified in interviews. Each entry included a written record with evidence of the corrective actions required, actions implemented, identification of the person responsible for the implementation, timeframes for implementation and sign-off after implementation.
		Staff, residents and family confirmed they knew the complaints process.
		Residents and family stated that complaints are dealt with promptly.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The clinical manager (CM) and charge nurses (CNs) discuss the Code with residents and their family during the admission process.
		Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private.
		The posters identifying residents' rights and advocacy services are displayed in throughout the facility in te reo Māori and English.
		Residents and families receive copies of the Oceania Healthcare Limited (Oceania) handbook which includes information on residents' rights and confirmed they had access to an advocate when needed. Residents and families confirmed their rights are being upheld by the service.
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	FA	A policy is available for staff to guide them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate manner, including strategies for the management of inappropriate behaviour.
		The service has a philosophy that promotes dignity, respect and quality of life. Private conversations are held in the resident's room and there are other areas in the facility which can be used for private meetings. Health care assistants (HCA) reported that they knock on

independence.		bedroom doors prior to entering rooms, this was observed on the days of the audit.
		Residents' files reviewed, including that of young people with disabilities (YPD), confirmed that cultural and/or spiritual values and individual preferences are identified. Younger people interviewed confirmed they can maintain their personal, sexual, cultural, religious and spiritual identity.
		The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and confirmed they know how to recognise abuse.
		There were no documented incidents of abuse or neglect in the business status reports or on the incident/accident forms reviewed in residents' files. Residents, staff, families and the general practitioner (GP) confirmed that there was no evidence of abuse or neglect.
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	There are processes in place to ensure residents who identify as Māori have their needs met. Policies and processes are in place and implemented to guide culturally safe services and to eliminate cultural barriers. Residents have access to Māori support and advocacy services if required. The Māori health plan includes the principals of the Treaty of Waitangi. The rights of the residents/whānau to practise their own beliefs are acknowledged in the Māori health plan, which forms part of the quality plan. Cultural training for staff is provided as part of the GEM study days. The diversional therapist (DT) completes cultural assessments on admission and reviews activity plans six-monthly.
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	Interviews with residents and families confirmed they are involved in the assessment and the care planning processes. Residents interviewed confirmed their spiritual needs are met. Residents' files reviewed demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents including family/whānau contact details. Documentation reviewed provided evidence that appropriate culturally safe practices are implemented and maintained. Care staff confirmed an understanding of cultural safety in relation to care.

| Standard 1.1.7: Discrimination

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policies and procedures are implemented to guide staff in good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation.

Job descriptions include the responsibilities of position including ethical issues relevant to the role.

Staff complete orientation and induction; including recognition of discrimination, abuse and neglect. Staff training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff confirmed they understand and would recognise discrimination. |
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| Standard 1.1.8: Good Practice

Consumers receive services of an appropriate standard. | FA | Policies include current good practice and are aligned with legislative requirements and guidelines.

Staff described practices based on policies and procedures. Staff have access to information on good practice as provided by governing bodies and specialists in the region.

The service has an annual staff training programme in place. Training is provided by specialist educators at structured study days and as part of the in-service education programme.

Registered nurses (RNs) attend education at the Hutt Valley District Health Board (HVDHB) and complete the professional development and recognition programme through the HVDHB. |
| Standard 1.1.9: Communication

Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and families. Accident and incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/EPOA of any accident/incident that occurs.

Clinical files reviewed evidenced timely and open communication with residents and their family members. Communication with family members is recorded in family/whānau records and progress notes. There is evidence of service providers' communication with the GP. Interviews with residents, including YPD, confirmed they are satisfied with the level and detail of communication. Service providers maintain communication records with families where required.

Families and residents are informed of the range of services provided. Residents sign an admission agreement on entry to the service. Admission agreements provide information around what is paid for by the service and by the resident. A facility newsletter is provided |

		monthly.
		Interviews with residents and families confirmed their satisfaction with the services provided at this facility. Interpreter services can be accessed from the district health board (DHB) when required. There were no residents at the facility needing interpreter services during the on-site audit.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Elderslea Rest Home has a documented mission statement, values and goals displayed in the foyer of the facility. This information is communicated to residents, staff and families through posters, information in booklets and in staff training. The facility is part of the Oceania group with the executive management team providing support to the facility. Meetings between the facility and executive management occur monthly with the regional CQM providing support. Monthly business status report provides the executive management with progress reports against key quality indicators. The business plan is specific to Elderslea with a mission/vision that is linked to the Oceania values. The Elderslea management team consists of a BCM who is supported by a CM, three CNs and an executive chef. The BCM is a RN who has worked in health management roles for the past 11 years and has been in the role of the BCM for nearly 3 months. The clinical care at the facility is overseen by the CM who is a RN with current annual practising certificate and has been in this position for approximately 18 months. The CM previously worked in the service as a CN. The management team is supported in their roles by the Oceania executive and regional teams and have completed induction and orientation appropriate to their respective roles. Elderslea is certified to provide rest home, hospital and dementia level of care for up 124 beds. There were 103 beds occupied at the time of the audit, including 41 residents requiring rest home level care, 44 requiring hospital level care and 18 residents being cared for in the dementia unit. The service has contracts with the DHB for the provision of care for long-term chronic conditions and respite care. There were two residents under the age of 65; one in the secure dementia unit and the second resident receiving care under the long-term chronic condition contract at hospital level. There were no residents with occupation right agreements.

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	There are systems in place to ensure continuity in day-to-day operations, should the BCM or the CM be absent. In the absence of the BCM, the BCM from another Oceania facility helps oversee the facility with input from the CM and support from the regional CQM operations manager. When the CM is absent, the CNs stand in with support from the regional CQM. Oceania national support office provides additional assistance when needed.
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	Elderslea uses the Oceania's quality and risk management framework. Policies and procedures guide operations and are subject to annual and bi-annual reviews. Policies are linked to the Health and Disability Services Standards, are current and align with legislation and evidenced based best practice guidelines. Staff confirmed they have access to policies in hardcopy and on Oceania's intranet. New and revised policies are presented to staff to read and staff sign to confirm they have read and understood the policy. Service delivery is monitored through the review of the complaints management processes; incidents and accidents management; surveillance of infections; pressure injury monitoring; soft tissue/wound reviews; and implementation of an internal audit programme. Review of the quality improvement data showed information is being collected, collated, evaluated, and analysed to identify trends. This information is reported to the national support office, staff and residents and their families where appropriate. Staff confirmed they are kept informed of quality improvements and changes within the service. The internal audit schedules and completed audits; incident/accident management processes, meeting minutes and complaints were reviewed for evidence of quality improvement through the documentation of corrective action plans when required. The service holds a variety of meetings including management meetings; staff meetings; quality meetings; health and safety; RN and resident meetings. Other meetings include; infection control and restraint meetings. Meeting agendas and meeting minutes are in template format. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Health and safety manual documents management systems including: a health and safety plan; employee participation; audits; accident reporting; injury management; hazard management; contractor agreements; and an emergency plan. Resident/family satisfaction surveys are completed six-monthly. Results confirmed residents' satisfaction with the levels of care they receive. Residents, including YPDs, confirmed their participation in decision making, and having access to technology and having the equipment

		they may need.
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	Adverse, unplanned or untoward events are recorded on an accident/incident form. Interviews with staff and review of documentation evidenced that staff document adverse, unplanned or untoward events on accident/incident forms which are reviewed by the CM and signed off by the BCM. Incident and accidents are recorded with detail on what occurred, the interventions with corrective actions identified, including neurological observations where indicated and re-assessment to identify changes in the condition of the resident which may have occurred. Incident and accident management processes are comprehensive and include possible reasons for events with actions on how this could have been prevented. The BCM is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles. HealthCERT has been informed of the appointment of the new BCM as well as the CM. Information relating to adverse event reporting is regularly shared at monthly meetings with accidents/incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities.
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 resource management processes are guided by policies and procedures which are aligned with good employment practices and current legislative requirements. The skills and knowledge required for each position is documented in job descriptions. Job descriptions outline accountability, responsibilities and lines of communication. Review of 11 staff files confirmed: employment agreements; reference checks; criminal vetting; drug testing; and completed orientation and competencies. Current copies of annual practising certificates were sighted for staff and contractors who require them to practise. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed. An orientation/induction programme is available and new staff are required to demonstrate competency on practice related activities. Health care assistants confirmed their role in supporting and buddying new staff. The organisation has an annual training and education programme which includes mandatory education and training. Staff complete in-service training around a variety of clinical topics.

		Attendance records for education session were reviewed and showed that ongoing education is provided during GEM and other study days. Education and training hours are at least eight hours a year for each staff member. The RNs' training records reviewed evidenced eight hours or more of relevant training.
		The service has fourteen RNs, including three CNs and the CM. Nine RNs had completed interRAI training. Annual competencies are completed by care staff, for example: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; and restraint. Staff working in the dementia unit completed the required unit standards or are in the process of completing the standards required to work with residents in the dementia unit.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing and skill-mix policies form the basis for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters showed that staffing levels meet resident acuity and bed occupancy.
		There are 120 staff, including the management team, clinical staff, leisure/activity staff, and housekeeping staff. There are at least two RNs on each shift. Care staff interviewed reported adequate staff is available and that workloads are manageable. Residents and families confirmed staffing is adequate to meet the residents' needs.
		The CM and CNs are on call after hours if required. Rosters reflect the skill mix of staff with appropriate numbers of staff to ensure safe care.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Policies and procedures provide guidelines to ensure privacy and confidentiality of residents' records. The service retains relevant and appropriate information to identify residents and track residents' records, including information collected on admission with the involvement of the family.
		The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals which are either directly entered by the user or are scanned in to the system. Resident records are in hard copy and medicines records are mainly in an electronic format.
		Staff interviewed described the procedures for maintaining confidentiality of residents' records. Resident care and support information can be accessed in a timely manner. Documents containing sensitive resident information are not displayed in a way that could be

		viewed by other residents or members of the public.
		Archived records are securely stored and easily accessed. Residents' progress notes are completed on every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes identify the name and designation of the person making the entry.
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' entry and the assessment processes are recorded and implemented. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. Potential residents are assessed using the interRAI home care assessment tool in the six months prior to the date of their admission. The information pack provided to all residents and their families contains all the relevant information. Interviews with residents and family and review of records confirmed the admission process was completed by staff in a timely manner. They also confirmed that they had received sufficient information prior to and on entry to the service.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The resident's exit, discharge or transfer is managed in a planned and coordinated manner. There is appropriate communication between families and other providers, that demonstrate transition, exit, discharge or transfer plans are communicated, when required. At the time of transition, appropriate information is supplied to the person/facility responsible for the ongoing management of the resident via the yellow envelope system. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made.
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	Medication management policies and procedures provide guidelines to ensure safe medication management practices. Medicines are provided by the pharmacy in a pre-packed delivery system. Drugs are stored securely with processes meeting medication legislation requirements. Medicines requiring refrigeration are stored separately in the medicine fridge and weekly temperature checks are within the recommended range. Weekly checks and six-monthly stocktakes are conducted and confirmed that the quantity of actual medications in stock reflected the expected stock levels. A computerised medication management system is used at the facility and meets the current legislative requirements and safe practice guidelines.

		All staff authorised to administer medicines have current competencies. A medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures.
		There were no residents self-administering medicines at the time of audit. Younger persons are supported to self-administer medicines where appropriate. There were no standing orders at time of audit.
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 executive chef oversees provision of food services at Elderslea. All food is prepared onsite in a large commercial kitchen. There is a current food control plan. The kitchen and the equipment are well maintained. Food in the chiller was covered and dated. The kitchen was clean, and all food was stored off the floor. Food safety information and a kitchen manual are available in the kitchen. All kitchen staff have completed relevant food safety training.
		There is a seasonal four-week cycle menu provided, that is in line with recognised nutritional guidelines for older people, as verified by a dietitian's assessment of the menu. Diets are modified as required. Special diets are catered for and documented in the kitchen. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The executive chef is made aware of any changes. Special equipment, to meet residents' nutritional needs, is readily available. Meals are delivered to the main dining rooms in covered trays and placed in bain-maries to maintain correct food temperatures. Food temperatures are monitored. Residents requiring extra support to eat and drink are assisted as observed during lunch.
		Food audits are carried out as per the yearly audit schedule.
		The service encourages residents to express their likes and dislikes. The residents interviewed spoke highly about meals provided and stated that staff ask them about their food preferences.
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	FA	The service has a process in place where access is declined, should this occur. When residents are declined access to the service, residents and their family are informed of the reason and of other options for alternative services. The referring agency, the GP and/or the nurse practitioner (NP) are informed of the decline to entry. Residents would be declined entry if not within the scope of the service or if a bed was not available as confirmed at management interviews.

appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents are admitted with a care needs level assessment completed by the needs assessment and service coordination (NASC) team prior to admission. Assessments are recorded, reflecting data from a range of sources, including but not limited to, the resident; family; GP and specialists. InterRAI assessments are completed within the required timeframes and available to staff. Risk assessment tools are reviewed at least six monthly including, but not limited to, falls, dietary, continence and pain. Residents interviewed confirmed assessments are conducted according to their needs and in a private manner. The RNs interviewed provided evidence of an understanding of the interRAI assessment process and how it is used to accurately identify the health risks, needs and goals of residents. Interviews with staff and review of documentation confirmed continuity of service delivery.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Person centred care plans are developed with the resident and family/whānau input is sought where appropriate. Short-term care plans are documented for the management of acute problems. Interventions in the PCCPs are detailed and reflect resident's current assessed needs. Residents' records are integrated, and progress notes, monitoring documents and observed handover evidenced continuity of care. In interviews, residents and family members reported residents' individual needs are met and they were actively involved in planning of care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents' needs are assessed prior to admission. There is evidence in the PCCPs of detailed medical specific plans, nutrition management, wound care plans, skin integrity management, falls prevention and pain management. Observation charts, weight and neurological observations are recorded within the required timeframes. Short-term care plans were implemented for acute problems. There was evidence of referrals to specialist services such as podiatry, physiotherapy, nutritional and specialist nurses. Medical records document reviews at least monthly or more frequently if needed. Interview with the GP confirmed they provide 24-hour, 7 day a week support. The GP stated the facility applies changes of care advice immediately and was complimentary about the quality of the service delivery provided. Residents can choose to retain their own GP. The care being provided is consistent with the needs of the residents. This was also evidenced by discussions with residents, family and staff. The RNs and HCAs follow the care

		plan and report progress against the care plan on each shift at handover. Nursing progress notes record changes. Family communication is recorded in the residents' files. Staff interviews confirmed they are familiar with the needs of the residents they are allocated to.
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 DT provides the activities programme at Elderslea across five days of the week. The DT is supported by five recreational officers and HCAs (who provide support for planned activities on the weekends). Interview with the DT and review of resident files confirmed the activities programme meets the needs of each service group. Residents are assessed to ascertain their individual needs, preferred activities and social requirements. The activities programme provides meaningful activities derived from resident assessments. The planned monthly programme for each area (rest home, hospital and dementia) was sighted and matched the skills, individual preferences and needs as evidenced by the resident's current assessments. The activities programmes include input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. A daily exercise programme and outings are provided for those residents able to participate. Activities social assessments, 24-hour activity plans and PCCPs are completed in a timely manner. In all files sampled there was evidence of resident, family/whānau involvement in the development of these plans. Review of resident files evidenced individualised activities plans based on current needs. On the days of audit residents were observed being actively involved in a variety of activities. Younger persons activities include, but are not limited to, maintaining local community involvement, assisting staff with activities or projects. Review of the two younger residents' files evidenced individual activities goals were documented and specific activities interventions match their goals. Interview with the DT and review of resident files confirmed residents' activity needs are evaluated regularly, as part of the formal six-monthly care plan review. The residents' activities attendance records are maintained, and activities progress notes are recorded monthly by the DT. Family/whānau and friends are welcome to attend all activities. The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programme and that management are responsive to requests.

Standard 1.3.8: Evaluation	FA	There was documented evidence that interRAI and PCCP reviews are completed six monthly or when there is a change in status. When a resident's progress is different than expected, the RN contacts the GP in a timely manner, as confirmed at the GP interview. Resident care is evaluated on each shift and reported in the residents' progress notes.
Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		
		Short-term care plans are initiated for short-term concerns, such as infections, wound care, changes in mobility and nutritional status. Short-term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. There was evidence short-term care plans were signed off once resolved or added to the PCCP if the problem was ongoing.
		Interviews with residents and family/whānau verified they are included in reviews and are kept informed of any changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	The service facilitates access to other medical and non-medical services. If the need for other non-urgent services are indicated or requested, the GP, RN or CM sends a referral to seek specialist service provider assistance from the DHB. Referral forms and documentation are maintained on resident files. There is information available pre-admission and in the admission documentation on the Code, advocacy, health practitioners code of conduct and informed consent.
Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
		Acute/urgent referrals are attended to immediately, sending the resident to the emergency department via ambulance if indicated. The GP interview confirmed they are informed of any acute changes in resident's condition in a timely manner and are involved in facilitating acute referrals to the DHB. Referrals are followed up on a regular basis by RN, CM or the GP.
		Review of documentation and interviews confirmed the resident and their family are kept informed of the referral process.
Standard 1.4.1: Management Of Waste And Hazardous Substances	FA	Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling and disposal and collection of waste.
Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		
		Interviews and observations confirmed personal protective equipment is provided, such as aprons, gloves and masks. Interviews confirmed that the use of personal protective equipment is appropriate to the risks. Observation confirmed that personal protective

		equipment such as aprons and gloves were used in high-risk areas.
		The hazard register is current. Material safety data sheets are available and accessible for staff. Staff receive training and education in safe and appropriate handling of waste and hazardous substances.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed in the entrance to the facility. Staff interviews, and visual inspection confirmed there is adequate equipment to support care, including care for residents with disabilities. The facility has an annual test and tag programme, and this is up to date, with evidence of checking and calibration of biomedical equipment. There is a system to ensure that the facility van that is used for residents' outings, is routinely maintained. A maintenance schedule is in place and implemented. Hot water temperatures are monitored and were noted to be maintained within recommended temperature ranges. Interview with the maintenance person and review of records confirmed that all residents' rooms/bathrooms are tested and monitored at monthly intervals. All resident areas can be accessed with mobility aides. These include internal courtyards and external gardens with outdoor seating and shade that can be accessed by residents and their visitors. Observation and residents and family interviews confirmed that residents can move freely around the facility and that the accommodation meets their needs, including secure gardens in the dementia unit. There are quiet areas throughout the facility for residents and their visitors to meet and there are areas that provide privacy when required. Residents interviewed, including the YPD, confirmed external areas meet their needs.
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	FA	There are accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility. There are currently five rooms that have full ensuite facilities and the remainder access shared toilet and bathroom facilities. Communal toilets have a system to indicate vacancy and there is appropriate disability access. Visitor toilets are conveniently located in the different areas of the service. Residents were observed being supported to access communal showers/toilets in a manner that was respectful and preserved resident dignity. The bathroom facilities are of an

requirements.		appropriate design to meet the needs of the residents. Residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned.
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	All rooms and suites facilitate single accommodation only. Resident rooms allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Resident interviews confirmed that there was space to accommodate: personal items; furniture; equipment; and staff as required. Residents and families are encouraged to make the room their own. There are designated areas to store equipment such as: hoists; commodes; wheel chairs; and walking frames safely and tidily.
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	There is a main lounge with seating and a view of the garden and smaller lounges with a view of internal courtyards and gardens. The dining rooms are situated in different areas of the facility, including one in the dementia unit. There are private areas for residents to access with their visitors if they wish, including places where YPD can find privacy. Observation and residents and family interviews confirmed that residents can move freely around the facility and that the accommodation meets their needs. The lounges are used for activities. Residents were observed to have their meals with other residents.
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	Facility laundry, including residents' personal clothing, is completed on site. Covered laundry trolleys and bags were observed to be used for transport. There is clear delineation of dirty and clean laundry. Residents and family members stated that the laundry standard met their requirements. Laundry staff interviewed confirmed knowledge of their role including management of any infectious linen. There are laundry staff on duty seven days a week. Health care assistants undertake aspects of laundry duties in the evenings. There are cleaners on duty each day, seven days a week and cleaning duties and procedures are clearly documented, to ensure correct cleaning processes occur. Cleaning

		products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaners store chemicals on a trolley when cleaning and were always observed keeping the trolley with them.
		Staff interviews confirmed that there is clear definitions and separation of, the roles of kitchen; cleaning; and laundry.
		Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility with alcohol gels and gloves in various locations.
		The effectiveness of cleaning and laundry processes are monitored through the internal audit process. Resident and family interviews and observation noted the facility to be clean and tidy and they were satisfied with the cleaning and laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Staff files and training records demonstrated that orientation and annual training includes emergency and disaster procedures and fire safety.
		An approved fire evacuation plan was sighted. Staff interviews, and documentation confirmed that fire drills are conducted at six monthly intervals. There is a monitored fire alarm; a sprinkler system installed throughout the facility; and exit signage displayed. Training records demonstrated that relevant staff have undertaken fire warden training. The most senior staff member on duty is the nominated fire warden for each shift.
		The staff competency register evidenced that all RNs have current first aid and cardiopulmonary resuscitation certificates. There is at least one and up to three staff members rostered on each shift with a current first aid certificate.
		There are supplies to sustain staff and residents in an emergency including alternative energy and utility sources that are available in the event of the main supplies failing. These include arrangements for the supply of an emergency generator; gas cylinders; a barbeque and gas bottles; lighting; food, water, and continence supplies. The service's emergency plan includes considerations of all levels of resident need, including YPD.
		There are call bells to summon assistance in all resident rooms and bathrooms. Where there is a sensor mat in the room, this connects to the room's call bell system. Call bells are checked monthly by the maintenance person. Observation on the days of the audit and resident and family interviews confirmed that call bells are answered promptly.
		There are security systems in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building and the facility being locked

		in the evenings and night time with restricted entry afterhours. The facility has sensor lights with security cameras in strategic areas.
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 accessed by residents have safe ventilation and external windows providing natural light. The internal facility environment was noted to be maintained at a satisfactory temperature for residents. Two of the communal areas had heat pumps. There is a water heating system for heating residents' rooms throughout winter. There are systems in place to obtain feedback on the comfort and temperature of the environment, including for example resident meetings. Resident and family interviews confirmed that the environment was maintained at a comfortable temperature. There are designated shaded external smoking areas and steps in place to ensure that smoking does not impact on other residents or staff.
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	An RN is the infection control nurse (ICN) and the role and responsibilities are defined in a job description. Infection prevention and control is tabled at the facility's meetings. Staff are made aware of new infections through daily handovers on each shift and residents' progress notes. Infection control management is guided by a suite of current infection control policies and procedures, developed at organisational level. There is annual review of the infection control programme. The facility's environment minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. Hand sanitisers and gels are available throughout the facility for staff, residents and visitors to use.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICN has the appropriate skills, knowledge and qualifications for the role and has been in the role for two years. The ICN completed training in 2019 on infection prevention and control through the DHB online education programme. This was verified in the training records reviewed. The ICN is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. The ICN has access to external specialist advice from Oceania senior management; GPs and

		DHB infection control specialists when required.
		Staff are made aware of residents' infections through staff handovers and residents' progress notes. The ICN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.
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	Oceania has documented infection prevention and control policies and procedures in place that reflect current best practice. The infection control manual includes a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and are current. Staff were observed to be following the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICN has attended relevant infection control education. Staff education on infection prevention and control is conducted by the ICN. Staff interviewed confirmed their understanding of how to implement infection prevention and control activities into their everyday practice. Information is provided to residents and visitors that is appropriate to their needs.
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	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files. In interviews, the ICN and management confirmed there was two outbreaks at the facility in 2017/2018. There was evidence this was reported to the required authorities and managed according to the Oceania outbreak management process.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint minimisation and safe practice 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 restraint coordinator is the CM who demonstrated knowledge of the organisation's policies, procedures and practices relating to restraint and enabler use. On the days of the audit there was two residents using restraint and no residents requesting the use of enablers. Clinical staff interviews confirmed enablers are used voluntarily at a resident's request. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the meeting minutes of the restraint approval group, review of the restraint registers and interviews with clinical staff and management.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint coordinator is supported by the Oceania national and regional management team regarding restraint practice and quality and risk considerations. The restraint coordinator has a signed position description for the role as part of their job description. Monthly reports are provided to the operational management team. The restraint use is approved by the clinical team, including the family and the GP. The approval process requires a full assessment of risk and evidence of trialled alternatives. The Oceania management team approves equipment which can be used as restraint within the Oceania facilities.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the standard. The initial assessment is undertaken by the RN with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The GP interviewed confirmed involvement in the final decision on the safety of the use of restraint. Review of the clinical records of the resident using restraint on the days of audit confirmed completed assessment and compliance with the approval process. The assessment identified, for example, the cause, alternatives, risk, cultural considerations and outcomes. The desired outcomes were to ensure the residents' safety and security.
Standard 2.2.3: Safe Restraint Use	FA	Staff and management interviews confirmed all restraints are used as a last resort and

Services use restraint safely		alternatives were discussed such as use of low-low beds, sensor mats and diversional activities. Once in place, restraints are monitored for safety. The restraint coordinator maintains a log of all restraint use. There have been no reported incidents related to unsafe restraint use. Restraint was observed to be in safe use during the audit.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is evaluated every two months and during the care plan review process. Monitoring forms evidenced the restraint use was being monitored when required. Staff interviews confirmed their awareness of the importance of restraint monitoring.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint reports for the month are collated and reported to Oceania operational management team. These reports include trends and any adverse/untoward events. Compliance with the restraint policy and procedure is monitored. Oceania national restraint authority group conduct annual quality reviews of all restraints used nationally.

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.

No data to display

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.