

Heritage Lifecare Limited - Ellerslie Gardens Lifecare

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](#).

The specifics of this audit included:

Legal entity: Heritage Lifecare Limited

Premises audited: Ellerslie Gardens Lifecare

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 15 August 2019 End date: 16 August 2019

Proposed changes to current services (if any): A reconfiguration was requested 23 May 2019 to reduce capacity from 97 to 87 beds by changing 10 double rooms to single rooms. A letter dated 28 May 2019 confirms the reversal of the request and bed capacity was changed back to 97 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 81



Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Ellerslie Gardens Lifecare provides rest home and hospital level care for up to 97 residents. The service is operated by Heritage Lifecare Limited and managed by a care home manager. The care home manager is supported by the clinical services manager. Residents and staff spoke positively about the care provided.

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 records, observations and interviews with residents, family members, managers, staff, contracted allied health providers and a general medical practitioner.

A reconfiguration was requested on the 23 May 2019 to reduce 10 double rooms to 10 single rooms reducing capacity to 87 beds. However a letter dated 28 May 2019 confirmed the reversal of this request and bed capacity was changed to 97 beds.

There were no areas identified for 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.
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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 interacted 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 was 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 efficiently by the care home manager. Compliments are shared with the staff. There is one external enquiry which has not yet been closed out.

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.
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Business and quality and risk management plans include the scope, direction, goals, values and beliefs of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

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/whānau. 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 managed effectively. A systematic approach to identify and deliver ongoing training supports safe service delivery and included annual staff individual performance review. Staffing levels and skill mix have recently been reviewed and a newly implemented roster system has been commenced.

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.		Standards applicable to this service fully attained.
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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.
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The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating. The gardens and grounds are well maintained.

Waste and hazardous substances are well managed. Staff use personal protective equipment and resources. Chemicals, soiled linen and equipment are safely stored. Cleaning and laundry are undertaken onsite and evaluated for effectiveness.

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Two enablers and two types of restraint are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme is led by an experienced and trained infection control coordinator who 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	50	0	0	0	0	0
Criteria	0	99	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	Ellerslie Gardens Lifecare 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 showed 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, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>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 a support person present.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints and concerns policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that 43 complaints had been received from 16 July 2018 to 29 July 2019 and that actions taken through to an agreed solution are clearly documented and completed within the required timeframes. All complaints are effectively closed out. The complaints register is maintained electronically by the care home manager. Staff education is provided on complaints management and all staff interviewed confirmed a sound knowledge and understanding of the complaint process and what actions are required. There is one coroner's case which has been open for four years and all information and any follow-up is filed appropriately and is maintained confidentially by the care home manager. There are no complaints with the Health and Disability Commissioner (HDC). Many letters and cards are received with compliments from families/whānau and residents and these are displayed for staff to read.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, in discussion with staff and at residents meetings. The Code is displayed in communal areas together with information on advocacy services, how to make a complaint and feedback forms.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. Six couples share a double room.</p> <p>Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor and participating in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>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. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledged and respected their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff 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. The service has many different ethnicities as residents and staff population reflected this as well.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct.</p> <p>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.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and 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.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included:</p> <p>Eight RNs are interRAI trained and the remaining three new RN's are in training.</p> <p>The service utilises online education for RN's and staff education included identified case studies relevant to current residents that includes best practice processes.</p> <p>'Tool-box' talks are regular and include early identification for emerging issues such as blanching of the skin for pressure injuries.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and 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.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to staff able to provide interpretation as and when needed as the resident ethnic population is reflected in current staff.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of</p>	<p>FA</p>	<p>The strategic and business plan, which is reviewed annually outlines the values, philosophy, scope, direction and goals of the organisation. The document described annual and longer term objectives and the associated operational plans. The 2019/2020 business plan reviewed outlines service specific goals to achieve. A sample of quarterly reports to the directors showed adequate information to monitor performance is reported including financial performance, emerging risks and any issues.</p>

<p>consumers.</p>		<p>The service is managed by an experienced care home manager (FM) who holds relevant management and registered nurse qualifications and has been covering the service for six years in this role. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency by attending study days at the DHB and training provided by Heritage Lifecare Limited HLL. The clinical services manager (CM) commenced at this facility and role in 2018. The clinical quality support RN was present for this audit in an advisory and supportive role.</p> <p>The service holds contracts with the district health board for hospital services (medical and geriatric), rest home, respite care, under 65 years younger people with a disability (YPD) and a long term chronic health (LTCH) contract. On the day of audit 81 residents were receiving services under the contract; 35 rest home, 43 hospital; two (YPD) rest home level, nil respite and one long term chronic health care resident.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical services manager is able to cover as required in the absence of the FM and is qualified to cover these duties under delegated authority with support from the clinical quality support nurse and the regional operations manager as required. The clinical services manager can cover and take responsibility for any clinical issues that may arise. The Heritage Lifecare Limited (HLL) clinical quality support registered nurse for this region was present at this audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation (HLL) has a planned quality and risk system and plan dated March 2018 to March 2020 that reflects the principles of continuous quality improvement. This includes the management of accidents and complaints, audit activities, health and safety, resident satisfaction surveys, monitoring of outcomes, clinical incidents including infections and pressure injuries. The care home manager ensures the goals set for the service are reported on in regard to progress against the set goals in their weekly care home manager's report. An education plan and staff training record spread sheet was sighted.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the governance meetings, monthly integrated meetings and staff meetings. Staff interviewed reported their involvement in quality and risk management through audit activities, weekly memos and their regular staff meetings. The 2019 audit schedule was available and reviewed. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed at</p>

		<p>least annually.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements including references 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. This is completed at support office.</p> <p>The care home manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The care home manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. The incident/accident is also recorded in the progress records, mentioned at handover and if needed the care plan would be updated. All serious incidents/accidents are reported to the RN on duty before the end of the shift. There are policies and guidelines for incident/accident management to guide staff which provides useful information on the response to different types of events including falls, abuse, infections, damage to property/equipment security and health and safety issues. A sample of incident 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 analysed and reported to management. An event log is maintained by the care home manager. Falls events are reported to the DHB for a falls programme in place.</p> <p>The care home manager described essential notification reporting requirements including pressure injuries. There have been 10 section 31 notices since October 2018 until 15 August 2019 (the date of this audit) reported to support office. The care home manager sends the Section 31 notices to the quality team at support office and then they are forwarded to the appropriate agency. These are also reflected and included on the clinical indicators reported monthly by the care home manager including, unintentional weight loss, falls with and without injury, skin tears, behavioural incidents and or medication errors, property loss and security issues. A summary which is loaded electronically onto the 'eCase' system and the statistics documented are forwarded to support office. The incident forms are filed in the individual residents' records.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process included referee checks, police vetting and validation of qualifications and practising certificates (APCS) where required. Qualifications of trained staff and allied health professionals including the registered nurses, general practitioners,</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>one nurse practitioner, two enrolled nurse, physiotherapist, pharmacists, dietitian, podiatrist and the pharmacy licence to operate are reviewed annually. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Job descriptions were sighted for each staff member depending on the role they undertake. Staff records reviewed showed documentation of completed orientation, a verbal review following orientation and a performance review after one year. A schedule was reviewed for completing the required annual staff performance appraisals.</p> <p>Continuing education is planned annually including mandatory requirements. Care staff (44) in total have either completed a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are thirteen registered nurses (including the clinical services manager) eight of whom are currently maintaining their annual competency requirements to undertake interRAI assessments. There are two registered nurse who are booked to complete the interRAI training. The (HLL) clinical quality support nurse is also competent in interRAI and is able to provided support and advice as needed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented allocation of staff/duty rosters policy to guide facility and clinical services managers. An electronic tool based on the indicators for safe staffing is used by the FM. The rosters reviewed cover 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call system is in place and staff interviewed reported that good access to advice is available when needed. Care staff interviewed in a group reported there were adequate staff available and that team-work was encouraged. Residents and family members interviewed supported this. Staff are replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage at all times. The service is covered and well supported with the FM working Monday to Friday 8am until 5pm and the CM working Monday to Friday 8am to 5pm.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>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.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p>

		Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC, general practitioner (GP) and family for residents accessing respite care.</p> <p>Residents and 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 details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service documents details on a paper transfer form 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 family have been kept well informed and all relevant information was included.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using 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 were competent to perform the function they manage.</p> <p>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 monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for</p>

		<p>accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's electronic details. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were two residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors on the electronic system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a qualified chef 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.</p> <p>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 and registration issued by the local council and expires 11 Dec 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutrition was available.</p> <p>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.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is 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</p>

<p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>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.</p> <p>Examples of this occurring were discussed and related documentation sighted. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and continence assessment, 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. All residents have current interRAI assessments completed by one of eight trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>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 were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff in handover as observed during the audit. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the 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 delivered according to instructions.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by two activities co-ordinators. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered.</p> <p>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 varied and interesting.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. 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, wounds, continence, behaviour and mobility. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a '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 medical and diabetes consultants. 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.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste, infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training</p>

<p>providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. A spill kit was available.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. There was evidence of a large clean out of order stored equipment awaiting collection by a contracted waste management contractor for recycling and this was moved at the time of the audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 10 March 2020) was publicly displayed.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities were fit for their purpose and maintained. Handrails are in place in the hallways. The building is all on one level. There are safe level pathways around the facility.</p> <p>The testing and tagging of electrical equipment and calibration of biochemical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to all the resident group and setting. The gardens are maintained.</p> <p>Residents confirmed and were observed demonstrating they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are pleased with the environment. The facility is accessible to meet the equipment and mobility needs of the residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>The facility is divided into six wings. Twenty four rooms have full ensuite bathrooms. Eighteen rooms have their own toilet and hand basins. All other individual rooms have a hand basin. All other toilets and showers are in close proximity to the residents' rooms in all wings where needed. Appropriately secured and approved handrails are provided in all bathrooms and other equipment and accessories are available to promote residents' independence.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Bedrooms provided are single or double accommodation. There are nine generous sized double rooms in total. Where rooms are shared approval has been sought. Each resident room and all service areas have a call bell system in place. All rooms were personalised with furnishings, photographs and other personal items being displayed. In all service areas visited there was adequate space to store total mobility scooters wheel chairs and walkers.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Furniture sighted was appropriate to the setting and residents' needs. There is one large dining area and lounge central to the facility which is used as the main activities room. There is a separate dining lounge area in wing two which accommodates mostly hospital level care residents. There is a small lounge in wing six which can be utilised as a family/whānau lounge or for private conversations if needed.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The laundry is undertaken onsite with a separate laundry being available. The staff interviewed are fully informed of their respective duties and have been in this role for many years. The staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and the handling of any soiled linen. Residents interviewed reported the laundry is managed well and personal clothing is returned in a timely manner. Chemicals are stored in a locked cupboard in close proximity to the laundry and kitchen and were clearly labelled. A contracted service provider provides all chemical training for kitchen, laundry and cleaning staff. Training was verified in the training records reviewed.</p> <p>The cleaners store their trolley appropriately in the locked sluice room when not in use. A refillable chemical system is in place. Protective equipment and resources are provided with good stores available when needed. Two cleaners work each day seven days a week and one laundry person is delegated seven days a week. Care staff assist as needed.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and temperature monitoring is managed effectively in collaboration with the maintenance staff and contracted service providers.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate</p>	FA	<p>Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence 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. The current</p>

<p>and timely response during emergency and security situations.</p>		<p>fire evacuation plan was approved by the New Zealand Fire Service 5 November 2013. A trial evacuation takes place six monthly with an outcome copy sent to the fire service, the most recent being on 19 June 2019. The orientation programme includes fire and security training. Staff interviewed confirmed awareness of the emergency procedures for all groups of residents.</p> <p>Adequate supplies for use in the event of a civil defence emergency including water, food, blankets, radios, torches and gas barbecues were sighted and meet the requirements for the 81 residents and for the local council in this region. Portable water and food is available for all emergencies. Water storage including a 2000 gallon tank is available. Emergency lighting is available and regular testing occurs. A generator would be hired if needed.</p> <p>The service has hot water supplies to the wings. The hot water is checked and monitored at the beginning of each month and recorded electronically by maintenance staff. One of whom works fulltime and the other part-time but both share the role.</p> <p>The service provider is working in partnership and is linked with the DHB emergency planning group. Training is provided to staff in relation to health and safety including emergencies, moving and handling and hazard training and this was sighted on the education plan.</p> <p>A call bell system is audited regularly and residents stated their calls to summon assistance are responded to by staff in a timely manner.</p> <p>Appropriate security arrangements are in place with a contracted security company of choice and staff are also responsible for the doors and windows on the afternoon and night shifts. Security cameras have been installed for approximately five years and signage was sighted. There is a bell for visitors and staff at the main entrance for the after-hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Heat pumps have been installed in the communal areas and electric wall mounted heaters are in all individual residents' rooms. Rooms have natural light, opening external windows. All service areas were warm and maintained at an even temperature. This was confirmed by the residents and families interviewed.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment,</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the HLL quality team. The infection control programme and</p>

<p>which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>manual are reviewed annually and evaluated three monthly.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical services manager, and tabled at the quality committee meeting. This committee includes the clinical services manager, IPC coordinator and unit coordinators. The committee reports to the care home manager.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role. She has attended 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 coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There have been no infection outbreaks since the previous audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed two yearly and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection</p>

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>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 handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical services manager, quality/IPC committee and are displayed on the nurses' station notice boards. Data is benchmarked externally within the HLL group using an electronic quality management system (eCase). This data has been collated by the Quality Manager and is reported through the senior management team to the GM and board of HLL. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standard and provide guidance on the safe use of both restraints and enablers. The restraint coordinator was available on the day of audit and provides support and oversight for enabler and restraint management in the facility. The registered nurse restraint coordinator interviewed demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the day of the audit two enablers were in use and two restraints. Enablers were the least restrictive and used voluntarily at the residents' request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, records reviewed and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval</p>	<p>FA</p>	<p>The restraint approval group is responsible for the approval of the use of restraints and the restraint</p>

<p>and processes</p> <p>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.</p>		<p>processes. There are clear lines of accountability, all restraints have been approved and there was evidence that the overall use of restraint is being monitored and analysed. Evidence of family/whānau involvement in the decision making was on record in each case. Use of a restraint or an enabler is part of the plan of care for the individual resident involved. The approval group meets six monthly to discuss the requirements of restraint monitoring and quality review and the needs of the resident and whether the restraint/enabler is meeting their needs.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement and input from the resident's family/whānau. The restraint coordinator interviewed described the documented process. Families confirmed their involvement. The GP is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraint is actively minimised and the restraint coordinator interviewed described how alternatives to restraints are discussed with staff and family members. When restraints are in use frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A separate restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received appropriate training and this was evidenced in the staff training records reviewed. Restraint minimisation and supporting people with challenging behaviours were also discussed. Staff interviewed understood that the use of restraint is minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p>	<p>FA</p>	<p>Review of residents' records showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval</p>

<p>Services evaluate all episodes of restraint.</p>		<p>group meetings. Families interviewed confirmed involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard including future options to eliminate use, the impact and outcomes achieved and if the policy and procedure was followed and documentation was completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a six monthly review of all restraint use which includes the requirements of the standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings confirmed this includes analysis and evaluation of the amount of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the doctor, staff and families. A six monthly internal audit as per the audit schedule reviewed is carried out and also informs these meetings. Any changes to policies, guidelines, education and processes are implemented from the support office if indicated. Restraint is minimised at this facility.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.