

Eastcliffe Orakei Management Services LP - Eastcliffe on Orakei

Introduction

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

The audit has been conducted by Q-Audit 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:	Eastcliffe Orakei Management Services LP	
Premises audited:	Eastcliffe on Orakei	
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 5 February 2020	End date: 5 February 2020
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:	25	

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

Eastcliffe on Orakei provides rest home and hospital level care for up to 28 residents. The service is owned by the local Iwi and managed by a nurse manager and a clinical/quality manager. The service is located within a retirement village. Residents and families 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/whanau, management, staff and a general practitioner.

The audit identified no areas requiring improvement and one area of improvement from the previous audit related to the infection surveillance has been fully met.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.	Green	Standards applicable to this service fully attained.
--	-------	--

Open disclosure and effective communication occur when required.

There is a documented complaints process in place that complies with the Code. The complaints register is well maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
---	--	--

A business plan and a comprehensive quality and risk management plan is documented and implemented which includes the objectives of the organisation. There is a process in place to regularly report against these goals three monthly.

The facility is managed by an experienced nurse manager who is well supported by a general manager, clinical quality manager and staff.

Quality improvement data is collected and discussed at staff meetings and staff were able to describe this. There is an internal audit schedule and internal audits are being completed in a timely manner. A corrective action plan is in place. Adverse events are documented and there is evidence of effective follow-up as required. Open disclosure is documented as appropriate and as it occurs.

There are policies to guide staff for all aspects of human resource management. There is a process for monitoring the annual practising certificates for all health professionals annually. An education plan is developed and implemented providing opportunities for staff learning new skills and covering topics that are mandatory and elective. Staffing is stable and orientation is provided for any newly employed staff members.

There is a documented rationale for determining staffing levels in order to provide safe service delivery. Care staff reported there are adequate staff available.

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 registered nurses (RNs) and general practitioner, assess residents' needs on admission. Residents and family where appropriate are involved in the development of individualised care plans. Any new problems that might arise are accommodated. 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.

There is a variety of activities planned that accommodate different needs of residents provided in groups or individual 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.
--	--	--

There is a current building warrant of fitness is displayed in the facility. Compulsory fire safety training is provided six monthly and reports are documented and were reviewed.

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 staff were aware of the implemented policies and procedures that support the minimisation of restraint. There were 11 enablers and no restraints in use at the time of audit. 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.
---	--	--

The infection prevention and control programme, led by the nurse manager who is the infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from external specialist when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education. The infection surveillance in place is suitable to the size and level of the services provided.

Infection surveillance is completed monthly, 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	17	0	0	0	0	0
Criteria	0	40	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do this. Complaints forms are readily available at the facility.</p> <p>The complaints register reviewed was explained by the nurse manager who is responsible for maintaining the complaints process. There have been eight complaints received since the previous audit. Three complaints in 2018 and five in 2019 and all have been closed out effectively. The complaints had been followed through to an agreed resolution, were documented within the appropriate timeframes. Action plans show any required follow-up and improvements have been made where possible. All staff interviewed confirmed a sound understanding of the complaint process and what actions were required.</p> <p>A complaint report was documented by the nurse manager for 2018 -2019 of all complaints and compliments received. A copy of the report is kept in the complaints register. There were two Coroner's cases in 2018 which were closed out. One recent Coroner's case in December 2019 was related to a village resident however, staff from the care home were implicated. This case has not been officially closed out at</p>

		the time of the audit. No other external complaints have been received.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy is clearly documented to include communication principles. Resident and family/whanau have a right to know what has happened to them and to be fully informed. There is a family/whanau communication record in the front of the resident's records reviewed.</p> <p>The cultural policy documents that residents and families who do not speak English shall be advised of the availability of an interpreter or an advocate at the first point of contact with the service.</p> <p>The service promotes an environment that optimises communication and staff education related to appropriate communication methods. The general practitioner (GP) interviewed spoke highly of the staff and the excellent communication and relationship between them and the GP also commented about the effective communication with the contracted pharmacist.</p> <p>Families interviewed confirmed they were kept informed of the resident's health status, including any adverse events adversely affecting the resident. Evidence of open disclosure is documented in the residents' records reviewed and on the incident/accident/near miss form.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans are reviewed annually and outline the purpose values, scope, direction and the objectives of the organisation. The documents reviewed described the annual objectives and associated operational plans. The nurse manager reports on occupancy, complaints, maintenance, quality data including health and safety and any emerging risks and/or issues. The nurse manager reports directly to the general manager on a monthly basis. The nurse manager has been in this role for eighteen years. The nurse manager is a registered nurse with a current nursing practising certificate which was sighted. Responsibilities and accountabilities are defined in the job description and individual employment agreement reviewed. The nurse manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at clinical and management ongoing education, held on-site and off-site through the DHB and with membership in aged care organisations.</p> <p>The Eastcliffe on Orakei supplies aged residential care services for private hospital</p>

		and rest home level care residents over the age of 65 years and holds contracts with the DHB. The service has 28 certified dual-purpose beds and on the day of the audit this reflected 20 hospital beds and five rest home level care beds were occupied totalling 25 residents.
<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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous improvement. This includes management of adverse events, complaints, audit activities, a regular resident survey, outcome oversight, clinical incidents including infections, falls, wounds and pressure injuries.</p> <p>Meeting minutes and quality data documentation reviewed confirmed regular review, analysis of quality indicators and the related information is reported and discussed at the management, quality, registered nurses' meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and implementation of corrective actions and ongoing projects. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family surveys are completed six monthly in May and November each year. The most recent survey showed that the majority of residents and family members were either satisfied or very satisfied with service provision. Family, residents and the general practitioner (GP) interviewed at the time of audit spoke highly of the care provided.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of any obsolete documents.</p> <p>The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The nurse manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The risk register is fully maintained up-to-date and signed off by the nurse manager.</p>
Standard 1.2.4: Adverse Event Reporting	FA	Staff document adverse and near miss events on an accident/incident/near miss form. A sample of incidents forms reviewed showed incidents were investigated,

<p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>action plans developed, and corrective actions were implemented in a timely manner. Open disclosure is documented, and it is noted on the form when family members have been informed. Incidents are discussed at the staff meetings.</p> <p>Staff interviewed confirmed that they are made aware of their responsibilities in this regard during their orientation and in policy and procedures.</p> <p>The nurse manger is aware of the essential notification requirements, including pressure injuries and these are documented in policy. The nurse manager advised there have been two section 31 notices completed and sent to HealthCERT since the previous audit. Two coroner's cases in 2018, one case 12 May was completed and 1 October 2018 the case was withdrawn.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies and procedures are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and performance review after a three-month period and then annually.</p> <p>There is an education plan for the next two years with several sessions confirmed with speakers. All mandatory education was provided and included in the education plan reviewed. The 2019 programme was reviewed and demonstrated that education was a continuous quality management project. Ten caregivers have attained level 4, 1 caregiver level 3 and four level 2 as part of New Zealand Qualification Authority education programme and to meet the requirements of the provider's agreement with the DHB. Registered nurses have completed numerous clinical competencies and all staff who administer medications have completed relevant competencies annually. The GP interviewed confirmed care is delivered to a high standard.</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals for interRAI.</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 process for determining staffing levels and skill mixes to provide safe service delivery 24 hours a day seven days a week (24/7). The nurse manager adjusts staffing levels to meet the changing needs of residents. This is confirmed on the rosters reviewed and during staff interviews. An after-hours on call roster is in place with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. The design of the facility is also taken into consideration when allocating staff.</p> <p>The nurse manager is supported by a senior experienced registered nurse who works four days a week as the clinical quality manager and one regular shift in a clinical role on the floor.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>A safe system for medicine management using an electronic system was observed on the day of audit. There is one resident who has a hard copy medication management record sheet. The resident's GP of choice is not as yet utilising the electronic management system. Medication is kept in locked cupboards in the nurses' station and in locked medication trolley. The RN observed administering medicines demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medication administration competencies are completed annually for all staff who administer medicines, current medication administration competencies were sighted.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs checks medications against the prescription and records of the checks were sighted on the electronic records and paper-based medication charts reviewed. There were no expired medications in the stock reviewed. Clinical pharmacist input is provided on request, for example to provide medication management training to staff or for any medication queries.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p>

		<p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The medicine charts had current residents' photos, allergies and sensitivities documented and the required three-monthly GP reviews was consistently recorded on the medicine chart.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended ranges and were consistently recorded. No vaccines are stored on-site.</p> <p>There was one resident who was self-administering medicines at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. Competency assessment records were sighted.</p> <p>The clinical and quality manager reported that any medication errors will be investigated, and analysed, and corrective actions put in place as required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by an external contractor There are two qualified chefs and the catering team. The food service is in line with recognised nutritional guidelines for older people. The menu follows a six-weekly cycle and was reviewed by a qualified dietitian within the last two years. The food is served in respective dining rooms and in individual residents' room if desired by the resident. Residents are free to join the village residents in the main dining room if desired.</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 safe plan and registration issued by ministry of primary industries that is valid until May 2020. Food temperatures, including for high risk items, fridge and freezer temperatures are monitored consistently and records maintained. The food services manager has undertaken a safe food handling qualification, with the catering team completing relevant food handling training.</p> <p>The RNs complete a nutritional assessment for each resident on admission and a dietary profile is 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. Copies of dietary profiles for residents were sighted in the kitchen records. The kitchen manager reported that the kitchen staff is updated of any changes to residents' dietary requirements promptly. Special equipment, to meet resident's nutritional needs, is available. Monthly weights were completed, and</p>

		<p>nutritional supplements were provided to residents who required them.</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 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documented interventions in the reviewed files were adequate and appropriate to address the individual residents' needs and desired outcomes. Observations and interviews with residents, staff and family verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The GP verified that medical input is sought in a timely manner, that medical orders are followed, and care is provided as prescribed. Caregivers confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</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>	FA	<p>The activities programme is provided by an activities coordinator with the help of the caregivers and overall supervision of the nurse manager.</p> <p>A social history assessment is completed on admission to ascertain residents' needs, interests, abilities and social requirements. The information gathered and resident observation is used as a basis to formulate the activities plan for each resident. Activities assessments were regularly reviewed to help formulate an activities programme that is meaningful to the residents. Residents' daily activities attendance records were maintained. The resident's activity needs were evaluated when residents' ability or significant change in attendance is noted and as part of the formal six monthly interRAI assessment and care plan review.</p> <p>The planned activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities are combined for rest home and hospital level residents. The weekly activities plan is provided to each resident on a weekly basis, copies sighted in residents' individual rooms and other copies were posted on the notice boards around the facility. Residents and families/whānau are involved in evaluating and improving the programme through feedback in residents' meetings and satisfaction</p>

		surveys. Residents interviewed confirmed they find the programme satisfactory.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<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 promptly.</p> <p>Long term care plan evaluations occur every six months following six-monthly interRAI reassessment, or as residents' needs change. The evaluations are resident focused and indicate the degree of achievement and response to interventions put in place. Where the expected outcome was not achieved, changes to the plan of care was initiated. Short term care plans were completed consistently for short term conditions and progress evaluated as clinically indicated. Examples sighted were for chest infections, wounds, urinary tract infections and post eye surgery. The RNs reported that when necessary, and for unresolved problems, the conditions will be added to long term care plans. Interviewed residents and family confirmed their involvement in evaluation of progress and any resulting changes.</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>	FA	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The building warrant of fitness was displayed, and the expiry date is 21 November 2020.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The service has an approved fire evacuation scheme by the New Zealand Fire Service and the date of the last six-monthly staff fire training was 20 January 2020.</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>	FA	<p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Monthly reports are provided by the laboratory. Surveillance data is evaluated and acted upon to assist in reduction of infections and is consistently documented. Results of the surveillance programme were shared with staff in staff meetings and at staff handovers. This was verified in staff meeting minutes sighted and in interviews with staff. Graphs are produced that identify trends for the current year and posted on the board in the nurses' station. Benchmarking against external providers is undertaken. The previous corrective</p>

		<p>action was addressed and closed out effectively.</p> <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, wounds, the upper and lower respiratory tract, skin eye and gastrointestinal tract infections. The infection control coordinator who is the nurse manager, assisted by an RN reviews all reported infections, and compile reports and share information with the other staff. Interviewed staff confirmed that new infections and any required management plans are discussed at handover to ensure early intervention.</p> <p>No infection outbreak reported since the last audit.</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>The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and responsibilities.</p> <p>On the day of audit, there were no residents using restraints and 11 residents were using enablers, namely five bedrails, five bed levers and one lap belt, which were the least restrictive and used voluntarily at their request. Regular evaluation of enablers in use was completed and records were sighted in reviewed files.</p> <p>Staff have received education on restraint minimisation and challenging behaviour management, training records were sighted. Interviewed staff demonstrated awareness of the difference between restraints and enablers. They were aware of the organisation's policy of using restraint as a last resort when all other alternatives have been explored.</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.