

Kohatu Resthome Limited - Kohatu Resthome

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:

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| Legal entity: | Kohatu Resthome Limited |
| Premises audited: | Kohatu Resthome |
| Services audited: | Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 1 September 2020 End date: 2 September 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: | 20 |

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

General overview of the audit

Kohatu Resthome provides rest home level care for up to 24 residents. The service is operated by Kohatu Resthome Limited and managed by a registered nurse manager. The service also provides a day care programme and meals on wheels to local Waitara residents. 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 Taranaki 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 and a general practitioner.

There were no areas identified as requiring improvement as a result of this audit.

Consumer rights

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| 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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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Kohatu Resthome. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided to residents of Kohatu Resthome in a manner that respects the choices, personal privacy, independence, individual needs and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

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

Organisational management

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| 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 describe the vision, purpose, objectives, back-ground of the service, current aspirations and the organisation's plans for the year. Monitoring of the service and providing information to the governing body is 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 any trends and leads to quality improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Any actual and potential risks including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using integrated hard copy files.

Continuum of service delivery

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| 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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The management staff of Kohatu Resthome, work closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care

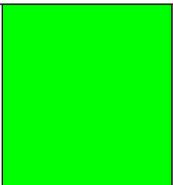
planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. Two facility vans are available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by senior care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

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| 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 appropriate for the care setting.

Waste and hazardous substances are well managed. Staff use personal protective equipment and clothing. Chemicals, soiled linen and equipment is tested as required. Laundry is undertaken onsite and the process is evaluated for effectiveness.

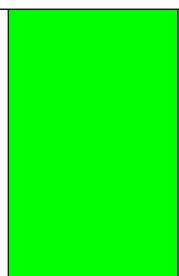
Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. All staff have completed first aid training. Residents reported a timely staff response to call bells. Security is well maintained.

Restraint minimisation and safe practice

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| 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 and meet all requirements of the restraint minimisation standard. There were no enablers or restraints 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 interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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| 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, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board and an external advisor. The programme is reviewed annually.

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, with data analysed, trended, benchmarked 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 | 45 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 93 | 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 |
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| Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation. | FA | Kohatu Resthome (Kohatu) has policies, procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff were observed to gain consent for day to day care on an ongoing basis. |

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| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service.</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. At the time of audit, group outings that involve social interaction with others, is being discouraged due to the related Covid-19 risks.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Visits from non-close family members, friends and people living outside the region, is being discouraged at the time of audit due to Covid-19 risks.</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>Kohatu Resthome has a comprehensive complaint standard to guide staff inclusive of the staff responsibilities, policies and procedures, clear definitions of major and minor complaints, use of advocates and documentation of verbal complaints as per Right 10 of the Code. Confidentiality is maintained when managing all complaints. There is in addition to the complaints standard; a flow chart with all Health and Disability Commissioner (HDC) timeframes. 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 seven complaints have been received since the previous audit and that actions were taken through to an agreed resolution and are documented and completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible.</p> <p>The registered nurse manager (RNM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There has been one HDC complaint received and this was followed through appropriately and effectively closed out by the HDC.</p> |

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| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>Residents (seven) and family members (ten) interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common 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> | <p>FA</p> | <p>Residents and family members of residents confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and during discussion with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to areas of interest and participation in clubs of their choosing. Each care plan 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 is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training records.</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> | <p>FA</p> | <p>There were four staff members and three residents in Kohatu at the time of audit who identified as Māori. Interviews verified staff can support residents 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 to Māori residents. There was a current Māori health plan developed with input from cultural advisers.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p> | <p>FA</p> | <p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well</p> |

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| services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | | residents' cultural needs are met, and this supported that individual needs are being met. |
| Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) contacted by phone, expressed satisfaction with the standard of services provided to residents of Kohatu.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. The registered nurse (RN) has a record of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> |
| Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard. | FA | <p>Kohatu encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, wound care nurse specialist, services for older people, psycho-geriatrician and mental health services for older persons, and education of staff. The 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 ongoing education. All staff are either qualified in caring for the older adult or have commenced training. Staff turnover is low with most caregivers having worked at Kohatu for many years.</p> <p>Examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided. This was evidenced through an ongoing initiative aimed at a reduction in the number of residents losing weight and staffs commitment to attendance at ongoing training sessions. Family and resident interviews expressed satisfaction at how friendly, welcoming and committed staff were in ensuring Kohatu was a friendly homelike environment. Family members commended the staff on how they 'went the extra mile' to ensure family were kept informed during the Covid-19 lockdown.</p> |
| Standard 1.1.9: Communication Service providers communicate effectively with consumers and | FA | Residents and family members stated they were kept well informed about any changes to their own or 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. There was evidence of resident/family input into the care planning process. Staff understood the principles of |

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| <p>provide an environment conducive to effective communication.</p> | | <p>open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via Interpreting at the Taranaki District Health Board (TDHB) when required and staff knew how to do so. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The Kohatu business plan 2020 to 2021 outlines the purpose, values, scope, direction and the objectives of the organisation. The documents described annual and longer term objectives, the background of the service, current aspirations and the associated operational plans. A sample of monthly management meeting minutes/records evidenced adequate information to monitor performance is reported including any emerging risks and/or issues.</p> <p>The service is managed by a registered nurse manager who is supported by the owners of the facility. The RNM holds relevant qualifications and has been in this role for 13 years. Responsibilities and accountabilities are clearly defined in a job description and individual employment agreement sighted. The RNM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending study days and conferences on business management and topics related to the aged care sector.</p> <p>The service holds contracts with the Taranaki District Health Board (TDHB) and Ministry of Health for rest home level care, respite care and under 65 non-aged care long term support chronic health conditions (LTSCHC). Twenty (20) residents were receiving services on the day of the audit. Rest home level care (16), under 65 years of age non-aged care (LTSCHC) two residents and there were (2) boarders at the time of audit.</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>When the RNM is absent, the nominated deputy (2IC) with the assistance of the owners carries out all the required duties under delegated authority. This appointed staff member has worked at this facility for approximately twenty years in various roles. During absence of the RNM, from a clinical perspective, the clinical management is overseen by a senior caregiver and the general practitioner for any clinical issues that may arise. Staff reported the current arrangements work well.</p> |

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| <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 has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections other key performance indicators (KPIs) such as falls, skin tears and any hospital admissions. The service has a robust system for internal auditing.</p> <p>Meeting minutes reviewed confirmed regular review and analysis for quality indicators and that related information is reported and discussed at the monthly management meetings and staff meetings. Staff interviewed reported involvement in quality and risk management activities through audit responsibilities assigned to them. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. Feedback from residents and families was very positive.</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 were current. The document review system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The RNM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager was 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> | <p>FA</p> | <p>Staff document adverse and near miss events on an accident/incident form. 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 collated, analysed and reported to the owners at the management meetings held monthly.</p> <p>The RNM described essential notification reporting requirements including for pressure injuries. The RNM advised there have been no notifications of significant events made since the previous audit.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p> | <p>FA</p> | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are well</p> |

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| <p>accordance with good employment practice and meet the requirements of legislation.</p> | | <p>maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff interviewed 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. Ongoing annual performance appraisals were documented in all staff records sighted.</p> <p>Continuing education is planned annually which includes all mandatory training requirements. The caregivers have either completed or have commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the TDHB. There are seventeen (17) caregivers nine of whom have completed level 3, one has completed level 4 and two are currently undertaking education for level 4. Two caregivers/cleaners have completed level 2 and three staff members are presently completing level 2. All certificates of attainment are displayed at reception. The RNM and all caregivers employed have current basic first aid certificates dated 14 August 2019. Care staff undertake laundry duties each shift and some trained caregivers perform designated cleaning duties.</p> <p>The RNM is responsible for all resident interRAI assessments, reassessments and updating of the care plans. Records reviewed demonstrated completion of the required training.</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 and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. The RNM covers the facility 24/7 seven days a week. Care staff interviewed reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observation and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All care staff have current first aid certificates ensuring (24/7) coverage in case of any incidents/accidents occurring.</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>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. 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. 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> <p>Residents' files are held for the required period before being destroyed. No personal or private resident</p> |

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| | | <p>information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</p> |
| <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 can enter Kohatu 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 meet with the RN Manager. They are also provided with written information about the service and the admission process.</p> <p>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.</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 uses the interRAI tool for the discharge or transfer of resident information between services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan 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 to seek additional input and advice showed transfer was managed in a planned and co-ordinated manner. The resident reported being kept well informed during the transfer.</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 identified 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 member being observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and</p> |

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| | | <p>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 signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>There was one resident who self-administered medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>Medication errors are reported to the RN manager and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</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 a cook 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 (18-05-2020). No recommendations were made at that time.</p> <p>A food control plan was in place and assessed by the New Plymouth District Council (19-02-2019). This expired in April 2020 and has been unable to be reassessed at this time due to Covid-19 and imposed restrictions. The Council via a phone call verified at audit, they would issue an interim compliance certificate. They are operating under a directive not to enter aged care facilities currently.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants 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 nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at mealtimes to</p> |

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| | | <p>ensure appropriate assistance is available to residents as needed.</p> <p>A previous continuous improvement initiative acknowledged in the previous certification audit remains in place. Residents noted to be losing weight have their meals dished up on a coloured plate. This alerts staff and kitchen staff to provide additional assistance and take special note of how much the resident eats. Additional foods are offered if intake is low. All these residents are weighed weekly. A review of these residents' nutritional records noted all but one of the residents on this programme have gained weight. The resident who has not gained weight has medical records verifying medical management is under review. A continuous improvement cannot however be awarded at this audit as there is no recent ongoing analysis of the initiative.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</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> | 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 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. Examples of this occurring were discussed with the manager. 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</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>On admission, residents of Kohatu are initially assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, cultural and nutritional screening, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require.</p> <p>In all files reviewed initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments were completed within three weeks of admission and at least every six months unless the resident's condition changes. Interviews, documentation, and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels. A resident has recently been transferred to another facility due to an increase in the level of care required. This process was discussed with the manager.</p> <p>All residents have current interRAI assessments completed by one trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p> |

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| <p>Standard 1.3.5: Planning</p> <p>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. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</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>Documentation, observations, and interviews verified the provision of care 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 of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</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 a trained diversional therapist.</p> <p>A social assessment and history are 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 regularly and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included exercises, dancing, crafts, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the monthly residents' meetings. Minutes indicate residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p> <p>Outings that involve socialising with other rest home residents and the public have been ceased at this time due to Covid-19 risks. Outings at this time include drives and activities and entertainment within the</p> |

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| | | facility which have increased. A social media page was started during Covid-19, to keep families in touch and informed about what was going on at Kohatu. Videos and photos were posted. |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN manager.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the RN responds by initiating changes to the plan of care. Examples were sighted of short-term care plans being consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. 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> | FA | <p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, 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 older persons' mental health services, eye specialists, urologists, and wound care specialists. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family 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 providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during</p> | FA | <p>Staff follow documented processes for the management of waste, infectious and hazardous substances. Appropriate storage is available outside of the facility in a locked shed. 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 for staff. Material safety data sheets (MSDS) were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of personal protective clothing and equipment (PPE) and staff were observed wearing this. Adequate stocks of PPE resources were sighted and are readily available for</p> |

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| service delivery. | | Covid-19 level 2 or any other pandemic events that arise. |
| <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>A current building warrant of fitness (BWOFF) is framed and publicly displayed in the entrance to the facility. The building warrant of fitness (BWOFF) was dated expiry of 07 March 2021.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities are fit for their purpose and are maintained. The maintenance person who has been employed for four months was interviewed and was well informed of all responsibilities involved with this role. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas were safely maintained and appropriate to the resident group and setting. Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required, that any requests are appropriately actioned by the maintenance person and that they were happy with the environment.</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> | FA | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Only one room has a designated toilet. All rooms have a hand basin. Toilets and showers were in close proximity to the residents' individual rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas and other equipment/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>There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. There are eighteen (18) individual and three designated shared rooms. No residents were sharing rooms at the time of the audit. Rooms were personalised with furnishings, photographs and other personal items being displayed. There was room to store mobility aids, wheelchairs and mobility scooters if needed. Staff and residents reported the adequacy of bedrooms and a homely environment is encouraged. Two hoists are available at the facility if needed, one being a standing/sling transfer hoist and one a transfer hoist.</p> |

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| <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 relax in and/or engage in activities. There is one large lounge with a conservatory and one small lounge accessible for residents and staff. Furniture is appropriate to the setting and to meet residents' needs. The conservatory and small areas with tables and chairs are available for dining purposes. The small lounge can be used if a resident wishes to have some privacy or a meal with family/whanau.</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>Laundry is undertaken on site in a dedicated laundry. Clean and dirty flow and designated areas were observed in the laundry. Handling of dirty laundry was observed and managed safely by staff involved. The care staff interviewed in a group demonstrated a sound knowledge of the laundry processes. Care staff were responsible for the laundry during their respective shifts. Material data sheets were observed in the laundry. Residents/family interviewed reported the laundry was well managed and the individual resident's clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team of care staff who have received appropriate training. All equipment and resources are readily available and cleaning schedules are in place for daily, weekly and monthly cleaning. Two of three staff designated to be cleaners have completed the New Zealand Qualifications Authority Certificate in Cleaning (Level 2) and one is presently completing this training as confirmed in interview of cleaning staff and review of training records. Chemicals were stored appropriately and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</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>Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service via the New Plymouth Fire Service, 31 March 1995. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent was 16 July 2020. The orientation programme includes fire and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas BBQ were sighted and meet the requirements for the twenty (20) residents as per the occupancy rate on the day of the audit. Two water storage tanks (for cleaning and laundry services) are located near the garage which stores all emergency resources inclusive of spare drinking</p> |

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| | | <p>water, PPE resources, continence products and other emergency supplies. The water stored meets the requirements of the New Plymouth Council for any emergency situation. A large waste bin holds all additional emergency equipment such as torches and non-perishable goods and this is checked regularly. There is no generator on site at the facility; however, the owner has access to two generators if and when needed. Emergency lighting is regularly tested. Each individual resident has a named grab bag in their wardrobe which contains a change of clothes, a torch and a fruit or chocolate bar for any emergency if evacuation is required.</p> <p>Call bells alert staff to residents requiring assistance. Call bell system audits are completed as part of the internal audit system and residents and families reported that staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Door and windows are locked at a predetermined time and staff ensure regular checks occur of the premises at night. Security cameras are in place throughout the facility and residents', staff and families are fully informed. Privacy is respected at all times. Night lights were evident in the hallways in each of the rest home wings during the tour of the facility.</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> | FA | <p>All residents' rooms and communal areas are heated and ventilated appropriately by a ducted ventilation system in the ceiling with vents opening into each individual resident's room and all communal rooms. Some rooms have doors that open into the courtyard. All areas were warm and well ventilated throughout the audit and residents and families confirmed the facility is maintained at a comfortable temperature.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>Kohatu provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed by an external IPC advisory company with input from the RN manager. The infection control programme and manual are reviewed annually.</p> <p>The RN manager is the designated infection control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and tabled at the monthly staff meetings and six weekly management meetings. Infection control statistics are kept in the organisation's infection database. The owner is informed of any infection control concerns.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48</p> |

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| | | <p>hours not to enter the facility. It also requests anyone to sign in on the Covid-10 QR code or manually, for contact tracing if needed. Anyone who is not a regular visitor to Kohatu, is questioned about the need to visit prior to entering the facility.</p> <p>The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell</p> <p>A Covid-19 management plan is in place as is an up to date pandemic plan. Staff are fully aware of the need to get a Covid-19 test if they are unwell, and to remain off work until it is clear. Family members and residents reported they are well informed regarding Covid-19 risks and Kohatu's management strategies in place.</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> | FA | <p>The infection control coordinator (ICC) has appropriate skills, knowledge, and qualifications for the role. The ICC has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the TDHB are available and expert advice from an external IPC advisory company, of which Kohatu subscribes to is also available. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources and PPE to support the programme and any outbreak of an infection.</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> | FA | <p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year 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, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p> |

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| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | <p>FA</p> | <p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICC and the infection control nurse from the TDHB. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred with the recent and ongoing Covid-19 outbreak. Education around this is ongoing.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing and advice about remaining in their room if they are unwell.</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, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC reviews all reported infections. 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 staff meetings and at staff handovers. Surveillance data is entered in the organisation's infection control database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>A 2020 analysis of infection data identified a much lower rate of respiratory tract infections this year compared to 2019.</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 standards and provide guidance on the safe use of both restraints and enablers. 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 role and responsibilities</p> <p>On the day of audit, no residents were observed using restraints and/or enablers. The restraint register was reviewed and no restraints or enablers have been used since the previous audit. Enablers when in use, are the least restrictive and are used voluntarily at a resident's request. A similar process is followed for the use of enablers as is used for restraints. Restraint is used as a last resort only when all</p> |

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| | | alternatives have been explored. |
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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.

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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.

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End of the report.