

Devonport Palms Retirement Limited - Devonport Palms

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 BSI Group New Zealand Ltd, 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:	Devonport Palms Retirement Limited
Premises audited:	Devonport Palms
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 August 2021 End date: 13 August 2021
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:	31

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

Devonport Palms is privately owned and operated and provides care for up to 34 residents requiring rest home level care. On the day of the audit there were 31 residents.

The service has an experienced management team. The managing director has contributed to the service for 17 years. The facility manager joined the team earlier this year and brings significant aged care experience and is supported by a skilled clinical manager. Residents and families interviewed were very complimentary of the care and support provided. Staff turnover remains low.

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

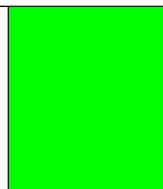
There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who live in the service. Implementation is supported through the quality and risk management programme. Quality initiatives are implemented which provide evidence of improved services for residents.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place. Resident files included service integration and input from allied health and specialists.

This certification audit has not identified any shortfalls at this audit.

Consumer rights

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



Standards applicable to this service fully attained.

Policies are documented to support resident rights and residents state that their rights are upheld. Systems protect their physical privacy and promote their independence. Individual care plans include reference to residents' values and beliefs.

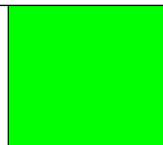
Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained.

Consents are documented by residents and there are advance directives documented if the resident is competent to complete these.

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.

The Cavell group quality management system describes Devonport Palms quality improvement processes. This includes a documented quality and risk management programme with data analysed and improvements made as a result of discussion. Benchmarking takes place to monitor performance against other 'like' organisations. Meetings are held at regular intervals to discuss quality and risk management and to ensure these are further embedded into practice. There is a health and safety management programme that is implemented with evidence that issues are addressed in a timely manner.

An orientation programme is in place and there is ongoing training provided as per the training plan developed for 2020 and 2021. Rosters and interviews indicate sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Registered nursing cover is provided for 40 hours a week with the clinical manager providing on call support.

The residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The clinical manager (registered nurse) is responsible for each stage of service provision. The clinical manager assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP) and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The clinical manager and medication competent caregivers responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged and/or subject to a regular visual inspection. All medical equipment has been serviced and calibrated.

Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Devonport Palms has restraint minimisation and safe practice policies and procedures in place. There is one resident requiring the use of a restraint and two residents using enablers. Staff receive training in restraint minimisation and management of challenging behaviour.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical manager) is responsible for coordinating education and training for staff. The infection control coordinator has completed annual training through an online provider in addition to Covid-19 education provided by the local DHB. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented and managers and staff interviewed (the managing director, facility manager, the current and newly appointed clinical manager, three caregivers, the cook, cleaner, diversional therapist) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme with the Health and Disability Advocate facilitating the training.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in six resident files (one hospital, and five rest home) were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Caregivers and the clinical manager (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative's lives.</p>

		Six resident files sampled have signed admission agreements.
<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>Information on advocacy services is included in the resident information pack that is provided to new residents and their family on admission. Advocacy brochures are also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services.</p> <p>Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service with training records confirming this. The advocate from the Nationwide Health and Disability Advocacy Services annually to give staff training around the Code and around advocacy services.</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>The service has an open visiting policy. Residents may have visitors of their choice at any time and family interviewed confirmed that they can visit whenever they like. The main doors lock at dusk however the service is accessible to family if they ring through.</p> <p>The service encourages the residents to maintain their relationships with their friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do as observed during the audit.</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>There is a complaints policy with responsibilities identified to ensure that all complaints (verbal or written) are fully documented and investigated. The facility manager is responsible at this facility for addressing any complaints.</p> <p>A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/family members in various places around the facility. There is a complaints' register that includes relevant information regarding the complaint. There has been one complaint lodged in 2020. The complaint was reviewed, and documentation confirmed that complaints are responded to in a timely manner as per policy. There have not been any complaints to date in 2021.</p> <p>Residents and family interviewed stated that they felt they could complain at any time noting that no residents or family had any complaints when interviewed. They also stated that the managers were 'extremely competent and visible' which allowed for discussion and encouraged any concerns to be raised.</p> <p>There have not been any complaints lodged with the Health and Disability Commissioner or other</p>

		external providers since the last audit.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. The facility and/or clinical manager/s discuss aspects of the Code with residents and their family on admission.</p> <p>Eight rest home residents interviewed confirmed that they received cares that met their needs, and all were aware of their rights. Four family members interviewed confirmed that staff had informed them of the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' personal belongings are used to decorate their rooms. Rooms have ensuites and there are communal toilets as well. All have a mechanism or way of determining if the rooms are occupied to ensure privacy.</p> <p>The caregivers interviewed report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed to occur during the audit. Caregivers reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and families interviewed confirmed that residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. Incidents were reviewed for 2021 and there are no incidents around abuse. Staff and the general practitioner interviewed confirmed that there was no evidence of abuse or neglect.</p> <p>There are spiritual services and residents are encouraged to attend their own spiritual care in the community if they can. There is at least one church service every three weeks. Any resident or family member can attend. Spiritual needs are individually identified as part of the assessment and care planning process.</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</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. There is one resident living at the facility who identifies as Māori and they were assessed for cultural needs as part of the interRAI assessment and care planning process.</p>

<p>respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>Managers and staff have connections with local kaumatua and kuia who attend the site for staff and Māori resident support and blessing of site/rooms post death as required. The service can also access support through the district health board if required. There are also three staff who identify as Māori who are able to speak conversational te reo and support any Maori resident culturally. The new clinical manager was identified as a kaupapa specialist nurse at the DHB and in the district nursing service. She is able to describe extensive networks with local iwi and kaupapa Māori service providers.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family, and/or their representative. Staff interviewed confirmed that they are committed to ensuring there is a consumer focus at all times. Beliefs and values are discussed and incorporated into the care plan as sighted in the review of resident records reviewed (five rest home and one hospital). Residents and families interviewed confirmed they are involved in developing the residents plan of care, which includes the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents.</p> <p>Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment, or financial exploitation. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and managers state that performance management would address any concerns if there was discrimination noted.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service meets the individualised needs of residents who have been assessed as requiring rest home care as confirmed through interviews with care staff and through an audit of resident files. The service has policies and procedures, equipment, and resources to support ongoing care of residents. The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Meetings are conducted to allow for timely discussion of service delivery and quality of service including health and safety.</p> <p>Residents and family members interviewed spoke very positively about the care and support provided.</p>

		<p>Both family and residents interviewed stated that the managers were very visible and encouraged open discussion at all times. Staff interviewed had a sound understanding of principles of aged care and person-centred care. Caregivers' complete competencies relevant to their practice.</p> <p>The general practitioner interviewed is satisfied with the care that is being provided by the service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed, confirmed they were given an explanation about the services and procedures and were orientated to the facility as part of the entry process. They also stated their relatives are informed of changes in health status and incidents/accidents with family interviewed confirming that they were kept informed at all times. A review of 16 incident forms confirmed that family were informed in a timely manner when incidents occurred.</p> <p>Resident and family meetings have occurred three-monthly. Residents and family confirm that they find the meetings useful and provide opportunities to raise issues or concerns. Residents and family interviewed confirmed that the managers have an open-door policy and resolve concerns proactively.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available through the District Health Board with phone numbers identified in policy. There are staff on site who speak a range of languages. There are no residents currently requiring the use of interpreting services.</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>Devonport Palms is owned and operated by a member/director of the Cavell group. The Cavell group is comprised of a group of independent aged care providers who share policies and provide collegial support while maintaining their independent businesses.</p> <p>Devonport Palms provides care for up to 34 residents requiring rest home level care. The building includes four 'care suites' which have been certified to have two residents at any given time. One care suite on the days of audit was occupied by a couple and the other three care suites occupied by single residents. On the day of the audit, there were 31 residents in total including one resident who had a special dispensation from the Ministry of Health to be in the service at hospital level of care. All residents were under the aged related residential care (ARRC) agreement.</p> <p>The service is managed by a facility manager who has extensive experience in aged care and disability services as well as in management. The facility manager has worked in the service for three months and has a Residential Care Association Certificate, post graduate diploma in management. The clinical manager is newly appointed (in the past month) to be in the role while the current clinical</p>

		<p>manager is on maternity leave. The current clinical manager and recently appointed clinical manager were both on site on during the audit. The new clinical manager has a background of nursing in intensive care services at the district health board.</p> <p>There is a Cavell Group strategic plan that includes objectives for the group. There is a risk management plan. The facility manager is responsible for the operational oversight of the business with the managing director responsible for the financial aspect of the business.</p> <p>The facility and clinical managers have attended at least eight hours of professional development that relates to management or clinical care.</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>	FA	<p>The facility manager reported that if they were on leave, the clinical manager and the managing director would fulfil the role with support from the care staff. The facility manager stated that they would organise a registered nurse to cover the service if the clinical manager was on leave.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The Cavell group quality management system describes Devonport Palms quality improvement processes. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff. A document control process is well established.</p> <p>Devonport Palms has a current 2021 quality plan that cascades from the strategic plan with goals and objectives relevant to the service. The goals and objectives for 2020 have been reviewed and were documented as being achieved. Goals and actions are reviewed monthly, and resolution documented as this occurs.</p> <p>Progress with the quality management programme has been monitored through the meetings including the staff meeting monthly, and the quarterly infection control and health and safety meetings. The meeting minutes sighted evidence tabling of data around health and safety, complaints, accidents/incidents, infection control, internal audit results, use of restraint, and survey results. Any corrective actions are documented with evidence that resolution occurs in a timely manner. There are three-monthly resident meetings and family are invited to attend. Benchmarking of data takes place</p>

		<p>with indicators measured and documented for the organisations involved in the Cavell group. Trends are analysed. Staff interviewed, confirmed they are well informed and receive quality management programme information and have involvement in discussions.</p> <p>The service has implemented a health and safety management system. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored at the relevant meeting. Hazard identification forms and an up-to date hazard register is maintained with this reviewed monthly. An annual resident and relative satisfaction survey with the last confirming that respondents are very satisfied with the level of care and service they receive. Falls prevention strategies are in place that includes the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>Since the last audit, there have been improvements made. These include a change from blister packs to Medi Rolls which are described as biodegradable, more cost effective and user friendly, improvements in food variety, presentation, and dining experience, refurbishment of lounges with outdoor furniture replaced and upgraded, and a post falls pathway process introduced.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Sixteen accident/incident forms for the months of June and July 2021 were reviewed. All document timely review and follow-up by the clinical manager. There is documented evidence the family had been notified of any incidents. Discussions with the facility manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There have been no section 31 notifications lodged since the last audit. There have been no outbreaks since the previous audit.</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>	FA	<p>There are human resources policies to support recruitment practices. Five staff files (facility manager, clinical manager, diversional therapist and two caregivers) were reviewed. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience, and suitability for the role. Performance appraisals were current with a further two caregiver records reviewed to confirm this as four of the five initial sample included staff who had been recently appointed. A current practising certificate was sighted for the clinical manager (and for the clinical manager who is soon to be on maternity leave).</p> <p>The service has an orientation programme in place to provide new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. There is an education planner in</p>

		<p>place that covers compulsory education requirements over a two-year period. Training is offered at the end of the monthly staff meeting and all staff attend (attendance records sighted).</p> <p>The clinical manager and caregiver's complete competencies relevant to their role such as medication, infection control and restraint. The clinical manager going on maternity leave has completed interRAI training. The new clinical manager is enrolled in the first available interRAI training course in the month following the audit. The clinical managers (including the one on maternity leave and the new clinical manager) receive training through the DHB with records sighted confirming this.</p> <p>Of the nine caregivers employed in the service, two have completed the level 4 certificate (CareerForce), one has completed level 3, three have overseas nursing qualifications that are equivalent to level 4, and three are currently studying for level 4. The diversional therapist is completing level 4 health and wellbeing specialising in diversional therapy.</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>	FA	<p>Devonport Palms has a roster in place, which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the residents' needs on different shifts.</p> <p>The facility manager and clinical manager are on-site from 8.30 am until 4.30 pm Monday to Friday and the clinical manager is on-call 24/7 with the facility manager also on call for any operational issues. The local general practitioner (GP) also provides after hours care if required and the caregivers have access to the local ambulance service.</p> <p>The clinical manager is supported by three caregivers on duty on the morning shift (two on a long shift and one on a short shift), two caregivers on duty on the afternoon shift and one caregiver on the night shift. Roster shortages or sickness are covered by casual or off duty staff. The caregivers and residents interviewed reported that there is sufficient staff cover.</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>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24-hours of entry into each resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in a secure room. Archived records are secure in separate locked areas.</p> <p>Residents' files demonstrate service integration. Entries are legible, dated, timed, and signed by the relevant caregiver or clinical manager, including designation.</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>	<p>FA</p>	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The clinical manager and facility manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment, and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents, and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The six admission agreements reviewed meet contractual requirements and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed state that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members report that the clinical manager or facility manager are available to answer any questions regarding the admission process.</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>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission into the facility.</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>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-medicating on the day of audit, who had been assessed as competent to self-administer by the clinical manager and GP. The resident's room was visited and confirmation that the medications were stored securely obtained. All legal requirements had been met. There are no standing orders in use and no vaccines stored on-site.</p> <p>The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The clinical manager and senior caregivers administer medications, have up to date medication</p>

		<p>competencies and there has been medication education in the last year. The clinical manager has syringe driver training completed by the hospice. The refrigerated medication and room temperatures are checked daily. Eye drops viewed in the medication trolley had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twelve medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The lead cook oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean, well-organised, and a current approved food control plan was in evidence, expiring July 2022. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked in line with the food control plan. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu is approved by an external dietitian. All resident/families interviewed are happy with the meals.</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>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whanau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed.</p> <p>Resident files reviewed identify that risk assessments are completed on admission and reviewed six-</p>

manner.		monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.
<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>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the dietician, wound care specialist and mental health team for older persons. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</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>When a resident's condition changes, the clinical manager will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the service and care provided.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included one arterial ulcer and one chronic wound related to oedema. There was evidence of wound nurse specialist involvement in chronic wounds management.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds. All monitoring requirements including neurological observations had been documented as required.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one full time diversional therapist and one part-time activities coordinator covering Monday to Friday who plan and lead all activities. The service designates weekends as 'family time' and also arranges visiting entertainers to attend on some weekends. Residents were observed participating in planned activities during the time of audit.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks around the nearby lake, crafts, games, quizzes, entertainers, pet therapy, floor games and bingo. Residents can also participate in a gardening group, men's group and ukulele group within the facility.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage are offered.</p> <p>There are monthly outings, and the service hires a community minibus and volunteer transport as needed. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as the salvation army, churches and children's groups.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were very positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long term care plans are evaluated by the clinical manager six monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six monthly multi-disciplinary review (MDR) is also completed by the clinical manager with input from caregivers, the GP, the activities team, resident and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is</p>

<p>(Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>maintained on resident files. The clinical manager interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. This was evidenced in the clinical file of the resident who had progressed to hospital level care within the service. Discussion with the clinical manager identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</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 service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a building warrant of fitness which expires January 2022. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs. There is a lift and stair access between the two floors. The lift can accommodate a bed/ambulance stretcher.</p> <p>Electrical equipment has been tested and tagged, expiring February 2023. The medical equipment and scales are checked annually and are next due to be checked July 2022. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and decked areas are well maintained. All external areas have attractive features, including mature gardens and vegetable beds, and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</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</p>	<p>FA</p>	<p>There are sufficient communal toilets and showers for those residents without an ensuite/shared ensuite. All bedrooms have hand basins. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. Privacy is assured with the use of ensuites. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, flooring, and wall coverings are good condition and are made from materials which allow for ease of</p>

privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Bedrooms are single with the exception of four apartments which can have double occupancy (one included a husband and wife at the time of audit). The rooms are spacious enough for the resident to easily manoeuvre around with mobility aids as required. Residents are encouraged to personalise their rooms as desired.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a large open plan lounge on the ground floor with access to the outdoor area. The upstairs area has a lounge with kitchenette, which allows for small group or individual quiet time and family visits. There is a separate resident dining room. All lounge/dining areas are easily accessed, spacious, inviting and appropriate for the needs of the residents. Residents are able to move freely and safely, and furniture is arranged to facilitate this. There is adequate space to allow for individual and group activities to occur within the lounges.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There is a cleaning policy and cleaning schedules are in place. Personal protective equipment is available in sluice/cleaning and laundry rooms. There is a defined clean/dirty area within the laundry. There were adequate linen supplies sighted. The cleaning trolleys are stored safely when not in use. Safety datasheets are available for cleaning and laundry staff. Staff were observed to be wearing appropriate protective wear when carrying out their duties. Cleaning and laundry audits have been completed. Residents expressed satisfaction with the cleaning and laundry service. There is a separate cleaner who works from Monday to Friday and a caregiver who is allocated on duty to complete the laundry services. Caregivers complete any extra cleaning or laundry during the weekend or as required.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during	FA	There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food and supplies (torches, radio and batteries), emergency power and barbeque. The facility keeps sufficient emergency water for 4 litres per person, per day for over 3 days for resident use on

<p>emergency and security situations.</p>		<p>site. A generator is readily available on rental through a local company.</p> <p>There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Security policies and procedures are documented and implemented by staff. The buildings are secure at night. There is security lighting externally.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</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>	<p>FA</p>	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control coordinator (clinical manager) is an RN who is responsible for infection control across the facility as detailed in the infection control coordinator job description (signed copy sighted on day of audit). The coordinator oversees infection control for the facility, reviews incidents and is responsible for the collation of monthly infection events and reports. The facility management team are responsible for the development of, and annual review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the Covid-19 and influenza vaccine. There have been no outbreaks since the last audit.</p> <p>An organisational COVID strategy and pandemic plan was available to staff on site with links to education and associated resources relating to hand hygiene, personal protective equipment (PPE), and donning/doffing procedures. Covid-19 education was also provided for all residents, including hand hygiene and use of PPE, these details being passed on to families via email and in writing. All visitors are required to provide contact tracing information.</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>There are adequate resources to implement the infection control programme at Devonport Palms. The infection control coordinator liaises with the infection control committee who meet regularly and as required (more frequently during Covid lockdown). Information is shared as part of quality meetings. The infection control coordinator has completed annual training in infection control through the local DHB.</p> <p>External resources and support are available through the Cavell groups infection control coordinator, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the Cavell group in conjunction with the facility management team.</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 infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by the Cavell group and facility management team.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating education and ensuring staff attend the in-service training provided. Training on infection control is included in the orientation programme. Staff have attended infection control education in the last 12 months. The infection control coordinator has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried</p>	FA	<p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Devonport Palms surveillance policy. The infection control coordinator uses the</p>

<p>out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the quality meetings. Meeting minutes are available to staff.</p> <p>Systems in place are appropriate to the size and complexity of the facility</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 policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirms their understanding of restraints and enablers.</p> <p>At the time of the audit, the service had one hospital level resident using a bed rail as a restraint, and two rest home level residents using a bed level as an enabler.</p> <p>Staff training is available around restraint minimisation and management of challenging behaviours, indications for restraint use, risks of using the restraint or enabler, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) are documented and understood. The clinical manager has a sound understanding of the restraint minimisation programme.</p> <p>The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The clinical manager, in partnership with the resident and their family, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations by the staff. Ongoing consultation with the resident and family was evident. The file for the resident using bed rails as a restraint, was reviewed. The completed assessments considered those listed in</p>

relation to use of restraint.		2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint approval process includes ensuring the environment is appropriate and safe. The assessment and care plan reviewed identifies specific interventions or strategies to trial (as appropriate) before restraint was used. The care plans reviewed for one resident with restraint, identified observations and monitoring with monitoring records indicating it is occurring at the frequency determined in the restraint assessment.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred at least three-monthly as part of the ongoing reassessment for the resident with documentation on the restraint register. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint programme, including reviewing policies and procedures and staff education, is evaluated annually through the Cavell group and staff in the service.

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.