

Kauri Lodge Rest Home 2008 Limited - Karui Lodge

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: Kauri Lodge Rest Home 2008 Limited

Premises audited: Kauri Lodge

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 21 September 2021 End date: 22 September 2021

Proposed changes to current services (if any): Forty-four spacious studio apartments with ensuites were verified at this audit as suitable to be used as double rooms for married couples. Advised that the service would only take up to 10 couples at a time. Overall bed numbers would therefore change from 60 to 70.

Total beds occupied across all premises included in the audit on the first day of the audit: 59



Executive summary of the audit




Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Kauri Lodge Rest Home provides rest home level care for up to 60 residents. On day of audit there were 59 residents.

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

Forty-four spacious studio apartments with ensuites were verified at this audit as suitable to be used as double rooms for married couples. Advised that the service would only take up to 10 couples at a time. Overall bed numbers would therefore change from 60 to 70.

The general manager (owner as part of the family business) is an experienced service operator. The general manager is supported by a clinical nurse manager, area manager and long-serving staff.

The residents and relatives interviewed all spoke positively about the care provided and this was reflected in the annual survey results.

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.

Care plans are comprehensive and updated for changes in health status.

This audit confirmed the service continues to remain fully compliant with all the standards.

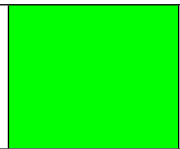
Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies are documented to support resident rights and residents stated that their rights are upheld. 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. Cultural policies and Māori Health plan are in place. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent. Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

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.


Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. There is a documented quality and risk management programme with key components of the system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, and review of risk and monitoring of health and safety, including hazards. Regular meetings are held that demonstrate a culture of quality improvement. An annual resident satisfaction survey is completed and there are regular resident/relative meetings.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff is in place and monitored. A roster provides sufficient and appropriate staff coverage for the effective delivery of care.

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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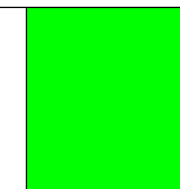
The registered nurses are responsible for each stage of service provision. The registered nurse assesses and plans, and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. The electronic medication charts reviewed met legislative prescribing and administration requirements and were reviewed at least three-monthly.

A diversional therapist coordinates and implements the integrated activity programme for the residents, along with the caregivers. The programme includes community visitors and outings when possible, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each consumer group. Residents and families reported satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are additional snacks available.

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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There are appropriate policies available in safe use of chemicals along with product safety data sheets. Reactive and preventative maintenance systems are established.

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and a dining area and private seating areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning.

Cleaning and laundry services for personal clothing and linen are available seven days a week and are monitored through the internal auditing system.

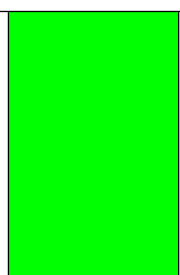
Appropriate security arrangements and a call bell system are in place. External areas including gardens and pathways are well maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service continues to maintain a restraint-free environment. Staff are trained in restraint minimisation, challenging behaviour and de-escalation techniques.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control coordinator is responsible for coordinating education and

training for staff and she has attended external training. There is a suite of infection prevention and control policies and guidelines to support practice. Surveillance of infections occur and there were no outbreaks reported since the last audit.

Covid-19 policies are available, and guidelines are followed to manage different risk levels.

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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with five care staff (the clinical manager, registered nurse, three caregivers and the diversional therapist) confirmed their familiarity with the Code. Eight residents and three family members interviewed confirmed the services being provided are in line with the Code. Staff have been trained in the Code of Rights.</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</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the eight resident files reviewed. Caregivers and registered nurses interviewed confirmed consent is obtained when delivering cares. All advance directives had been appropriately signed by the resident and general practitioner (GP). Advance directives also identified the resident resuscitation status.</p> <p>The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident.</p>

give informed consent.		
<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>Clients right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service entrance area. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members interviewed were aware of their access to 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>Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to resident/relatives at entry and is available with complaint forms at the reception area. There is a complaint register that is up to date and includes relevant information regarding the complaint. There have been five complaints since their last audit (four from the same person). Two of the complaints have been forwarded to HDC and the service is providing feedback in response to these. The complaints folder included appropriate follow-up with the complainant including a meeting and evidence of resolution.</p> <p>A complaints procedure is provided to residents and relatives within the information pack at entry. Interviews with residents and relatives confirmed understanding of the complaints process and that they felt confident that their concerns and issues would be dealt with appropriately by staff and management.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code and advocacy pamphlets are located at the main entrance of the service. On admission, the clinical manager and/or general manager discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about 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>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Staff have completed training around privacy and confidentiality June 2021. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. Interviews with a married couple confirmed that they are given privacy. There is a policy on abuse and neglect and staff have received training, last completed July 2020.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has guidelines for the provision of culturally safe services for Māori residents. There is a Māori health plan. There are currently no residents that identify as Māori. Discussions with staff confirmed that they are aware of the need to respond with appropriate cultural safety. Cultural safety training was last completed August 2021. The service has links with the DHB to access Māori advisors as needed. There is a Māori health and Cultural Safety policy.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan. Staff interviewed confirmed their understanding of cultural safety in relation to care. Residents and family members interviewed confirmed that staff respect their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	FA	<p>There are policies and procedures in place to protect residents 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 policy and job descriptions. Staff sign a confidentiality clause and house rules on employment.</p>

<p>harassment, sexual, financial, or other exploitation.</p>		<p>Staff interviewed demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives reported that staff maintain appropriate professional boundaries, including the boundaries of the care partner role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are policies and procedures to guide practice. These align with the Health and Disability Services Standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by an external aged care consultant. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice with this able to be described by clinical staff.</p> <p>The education programme includes mandatory training requirements for staff and other significant clinical aspects of care delivery. There is low staff turnover. The outcome of the 2021 resident satisfaction survey was very positive.</p> <p>Family members interviewed confirmed they are satisfied with the care provided. Residents interviewed were happy with all aspects of care.</p> <p>There are implemented competencies for caregivers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy in place. Residents are provided with a range of information on admission regarding the scope of service and any items they have to pay for that are not covered by the agreement. Communication with family members is recorded on the electronic incident report forms and in the resident daily progress notes. Ten incident forms (August/September 2021) reviewed identified that family were notified following a resident incident. Quarterly resident meetings include discussion around the services provided. Regular Covid updates are provided to family and residents. Eight residents interviewed described open communication with management.</p> <p>The information pack is available in large print and can be read to residents who are visually impaired. An interpreter is available as required. The 2021 resident satisfaction survey identified that 100% residents were happy with communication.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures</p>	<p>FA</p>	<p>Kauri Lodge Rest Home provides rest home level care for up to 60 residents. On day of audit there were 59 residents including two married couples across two double studio rooms. All residents are under the ARCC contract. Forty-four spacious studio apartments with ensuites were also verified at this audit as suitable to be used as double rooms for couples. Advised that the service would only take up to 10 couples. Overall bed</p>

<p>services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>numbers would therefore change from 60 to 70.</p> <p>The general manager (owner as part of the family business) is an experienced service operator and owns three aged care facilities in Christchurch. The general manager is based at Kauri Lodge and is supported by a clinical nurse manager, and area manager. The general manager is an experienced aged care manager and has been involved in the management of Kauri Lodge for over 12 years.</p> <p>There is a strategic plan 2018-2022 which includes four objectives. There is a Business Operation Plan 2021-2022. There are five objectives identified in the Quality Improvement 2021 plan. Progress to meeting these objectives is discussed through the QI/management meeting as evidenced in meeting minutes.</p> <p>There is a documented risk management schedule which is regularly reviewed through meetings. The 2020 quality and risk objectives were reviewed, and meeting minutes identified three were completed and two are ongoing.</p> <p>The general manager and clinical nurse manager have completed at least eight hours of training related to managing a rest home.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The service's administrator is delegated with the responsibility of fulfilling the general manager role in his absence and is supported clinically by the clinical nurse manager and area manager. The service has well developed policies and procedures and service delivery is meeting residents assessed needs.</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</p>	<p>FA</p>	<p>Kauri Lodge implements a comprehensive quality and risk management system with ongoing improvements identified on a QI register. Interviews with the manager, team and staff reflected their understanding of the quality and risk management systems. There are five objectives identified in the quality improvement plan for 2021.</p> <p>The policies and procedures and associated implementation systems provide an appropriate level of assurance that it is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed as evidenced through meeting minutes. New policies or changes to policy are communicated to staff.</p>

<p>principles.</p>		<p>Resident meetings occur three-monthly. Meeting minutes reviewed included follow-up and actions where residents have suggested areas for improvement. A resident/relative survey is completed annually. The 2021 survey result was overall very positive with 100% across 16 of 19 areas. The surveys were collated and reported to residents/relatives and staff. There were no areas in the survey that required corrective actions.</p> <p>There is a monthly monitoring, collation and evaluation of quality and risk data. An annual internal audit schedule is implemented, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data are discussed in two/three monthly quality and risk meetings, one/two management meetings and 3x yearly staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed (as sighted on QI register). Annual quality goals are reviewed at each meeting.</p> <p>Falls prevention strategies are in place and implemented individually for residents. A health and safety system is implemented. Health & Safety is part of the quality meeting. Hazard identification forms and a hazard register are in place. A six-monthly hazard review is completed and discussed at the quality meeting.</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>Incident reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Ten incident forms (August/September 2021) were reviewed on the new electronic system. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. The service follows CDHB head injury guidelines where the resident hits their head in a fall. Two incident forms reviewed where the resident potentially hit their head included follow-up assessment and observations to identify any changes in the resident.</p> <p>Incidents have been benchmarked across the last three years. Recently, benchmarking has commenced through an online system with an aged care consultant. Incident/accident data is linked to the facility quality and risk management programme and is used for comparative purposes and analysed for trends.</p> <p>The general manager was aware of the requirement to notify relevant authorities in relation to essential notifications. There have been no reportable events 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</p>	<p>FA</p>	<p>Six staff files were reviewed (two RNs, three caregivers, and DT). All reviewed identified implemented processes around recruitment, selection, orientation and staff training and development. There are job descriptions available for all relevant positions and all staff had employment contracts. All staff had relevant qualifications related to rest home care. There are 14 caregivers at Kauri Lodge, two caregivers have level one, ten have level three and two have level four. The clinical nurse manager is interRAI trained. A record of practising certificates is maintained for all health professionals.</p>

<p>practice and meet the requirements of legislation.</p>		<p>Orientation for new care staff includes a buddy system with an existing staff member. New staff are assigned a 'mentor' who ensures that the orientation checklist is completed and signed off. Self-directed quizzes are completed. Records of completion of orientation are retained on staff files. Competencies are completed including medication, manual handling, hand hygiene, first aid and medication-2nd checker.</p> <p>The service completes performance appraisals annually for all staff against the relevant job description. A 2020 and 2021 education programme has been implemented which exceeds eight hours annually. The service implements a number of training sessions through onsite in-services and via online training modules. A training register is maintained.</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>The service has a documented staff rationale that outlines the requirements for staffing of the service. The service has a total of 31 staff in various roles. Staffing rosters were sighted and there is staff on duty to match the needs of different shifts.</p> <p>At least one staff member on each shift/duty holds a current first aid certificate. Rosters evidenced caregiver and RN mix, with the RNs on call afterhours. There is RN cover from 0700 – 1530 seven days a week.</p> <p>There are five caregivers rostered in the morning (0700 – 1530, 0700 – 1500, 0700 – 1300, 0700 – 1200, 0700 – 1100) and two on the afternoon shift (1520 – 2320) plus one on short shift (1700 – 2000) and two on a night shift (2315 – 0715 and 2315 – 0800). Staff, residents and relatives interviewed stated that staffing levels are good and staff turnover is low.</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 service retains relevant and appropriate information to identify residents and track records.</p> <p>There are paper based files appropriate to the service type available. Staff could describe the procedures for maintaining confidentiality of resident records. Resident files and relevant care support information are able to be referenced and retrieved in a timely manner.</p> <p>Entries are legible, dated and signed by the relevant caregiver or RN including designation. All resident records contain the name of the resident and the person completing the form/entry. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a</p>	<p>FA</p>	<p>There are pre-entry and admission procedures in place. All long-term resident files evidenced approval for the level of care by assessment coordinators. The clinical team liaises closely with the assessing teams to ensure the service can meet the assessed resident needs.</p> <p>The service has a well-presented information booklet for residents/families at entry. Three family members</p>

<p>competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>interviewed stated they received sufficient information on the services provided and were appreciative of the staff support during the admission process.</p> <p>Admission agreements reviewed in all electronic files align with contractual requirements. Admission agreements had been signed within a timely manner, where enduring power of attorney (EPOA) has been activated (or not) the applicable letters and documents were placed in the resident's file.</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. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</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>The medication management policies and procedures comply with medication legislation and guidelines. All medications and medication trolleys are stored safely in the locked nurses' station. There are monthly checks for any expiry dates. Kauri Lodge uses an electronic medication management system. Medications are checked on arrival and discrepancies are fed back as errors to the pharmacy. Medication errors are documented on incident forms and discuss at the relevant meetings. Regular medication internal audits are completed, and any corrective actions required are implemented and signed off</p> <p>Registered nurses and senior caregivers administer medications and completes annual medication competencies. Policies and procedures support practice and training has been provided. Self-administration of eyedrops by residents (two in the hospital) is managed as per guidelines and policy. The GP interviewed advised that three monthly medication reviews are completed and a minimal attitude to strong painkillers is adhered to. Staff were observed safely administering medications on the days of audit. There are no nurse-initiated medication lists or standing orders.</p> <p>Sixteen electronic medication files were reviewed. All files reviewed evidenced the resident's photograph, allergy status and correct prescribing.</p> <p>'As required' medication was appropriately prescribed and administered, and effectiveness noted in either the comments section of the progress notes or the electronic medication management system itself.</p> <p>Storage of medications including, room temperatures and refrigeration temperatures, were correctly managed and documented. Medications were within expiration and eye drops were dated.</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>Kauri Lodge has a large, well-equipped kitchen where all meals and snacks are prepared. The qualified chef was able to discuss the food service and was knowledgeable regarding the current menu and all aspects of food service. The chef is supported daily by a weekend cook and a morning (x1) and afternoon (x2) kitchenhands. The roster is adequate for the size of the facility.</p> <p>The menus are reviewed by a dietitian and last reviewed in August 2021. All kitchen staff are trained in food safety. The fridge and freezer temperatures are recorded daily, and food temperatures are recorded at mealtime.</p> <p>The meals are served and plated directly from the bain marie in the kitchen to the adjacent dining room. Plates are name labelled where special dietary requirements are known. The chef or cook receives a nutritional assessment for each new resident and is notified of any changes, special diets, dietitian instructions or weight loss.</p> <p>Cultural, religious and food allergies are accommodated.</p> <p>Special diets accommodated are gluten free, dairy free, modified diets such as soft, mince and moist. The chef interviewed could identify residents with special nutrition needs like swallowing difficulties and weight loss. The lunch meal was observed in the dining room, enough care staff were available in the dining room to assist residents when required. Additional food and snacks are available and accessible any time of the day.</p> <p>Residents and family members interviewed expressed satisfaction with the meals and individual likes, dislikes and preferences are catered for. Food profiles, dietary needs and allergies are recorded. Weight monitoring occurs and the dietitian is involved with any residents who are experiencing significant weight loss. A food first approach to weight loss is implemented. Supplements and fortified meals are provided to those residents requiring these. A food control plan is in place and local council verification has occurred with a current annual certificate displayed. The food control plan is current and expires 21 May 2022.</p> <p>The chemical provider completes a monthly check on the dishwasher function and temperatures. A cleaning schedule is maintained. The dry goods store has all goods sealed and labelled. The kitchen staff were observed wearing appropriate personal protective clothing. Feedback is received from meetings, family members and through annual surveys. The chef attends resident meetings when required and assists with food related concerns. Residents and relatives interviewed were satisfied with the food service, choices and option available.</p> <p>Nutritious snacks and fruit platters are available.</p>
<p>Standard 1.3.2: Declining</p>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the care required or there are no beds available. Management communicates directly with the</p>

<p>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>		<p>referring agencies and family/whānau as appropriate if entry is declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RNs complete an initial assessment on admission including risk assessment tools. The information gathered at admission such as allied health notes, needs assessment, discharge summaries and discussion with the resident, EPOA and family/whānau is used to develop care needs and support to provide best care for the residents.</p> <p>An initial assessment covers all activities of daily living and specific assessment tools are used for behaviour, falls risk, nutritional risk and a pain assessment. The falls risk assessment tool is repeated for any resident with three falls or more in a month. An interRAI assessment is undertaken within 21 days of admission and six monthly or earlier, due to health changes. Residents identified with swallowing difficulties and unintentional weight loss had a comprehensive nutritional assessment completed.</p> <p>The diversional therapist completes a comprehensive social assessment in consultation with the resident/family. Eight residents' files reviewed included an individual assessment that included identifying diversional, motivation, social, cultural and recreational requirements. Behaviour assessments had been completed for one resident with inappropriate behaviour.</p> <p>InterRAI assessments, assessment notes and summary were in place for the resident files reviewed. The long-term care plans in place reflected the outcome of the assessments and the triggers identified.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), EPOA, family/whānau and care staff. The long-term care plan is developed within three weeks of admission. The outcomes of interRAI assessments form the basis of the long-term care plan. The care plans reviewed documented interventions to meet the resident needs including daily activities, sleep and rest, mobility and falls prevention, pain management, food and fluid/nutritional status and medical and medication needs.</p> <p>Eight resident files were reviewed; all care plans reviewed included identified needs and interventions to support these needs. Short-term care plans were documented for infections and used for other short-term needs, reviewed and either resolved or appear as part of the long-term care plan.</p> <p>Care plans demonstrate allied health input into the resident's care and wellbeing including the</p>

		<p>physiotherapist, dietitian, wound nurse specialist, speech and language therapist and podiatrist. Allied health professionals' health instructions were executed as requested and identified in the care plan.</p> <p>InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process. Family members interviewed confirmed they are involved in the care planning process. Long-term care plans are sighted by relatives where required in the form of a summary plan on the three-monthly clinical review document. This is then kept in the file. There is evidence in the sampled files of residents' signing and acknowledging their own care plans. Residents are encouraged to maintain independence and current abilities.</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>	<p>FA</p>	<p>When a resident's condition changes the RN initiates a GP consultation. Short-term care plans are completed for changes to care/supports required and communicated at handovers. Registered nurses (RNs) and caregivers follow the care plan and report in progress notes each shift. There is evidence in the medical notes of the GP communication with other referral agencies in regard to medical reviews. The relatives interviewed stated their expectations were being met and they were notified of any changes to health, incidents, infections, GP visits and medication changes (if required).</p> <p>Observation on the day also included caregivers' communication to be appropriate and effective with residents with hearing impairment.</p> <p>Staff have access to sufficient medical and clinical supplies available such as equipment and dressings. All wounds have wound assessments, pain scores, photos, sizes, dressing plan and evaluations completed on the due dates. There was a total of nine current wounds treated including skin tears and three chronic wounds including lower leg ulcers. There has been wound specialist input identified for one of the chronic wounds.</p> <p>Wound management policies and procedures are in place. Wound assessments, evaluation and monitoring documentation were completed within required timeframes for each of wounds; there were no current treatment of any pressure injuries. Residents with high risk of undernutrition and risk of skin breakdown are proactively managed to associated risks. Three residents (smokers) have appropriate plans to manage smoking risk and there was evidence of smoking cessation offered.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan as part of the care planning process. Specialist continence advice is available when needed (however seldom required in last 24 months) and this could be described.</p> <p>The monitoring charts were maintained as required and identified in the care plan interventions. Monitoring forms include pain, observations, neurological observations, 24-hour fluid intake, blood sugar levels, weight, food and fluid, resident hygiene and bowel charts and challenging behaviour. All monitoring forms are</p>

		completed and kept in the resident file. The RNs review the monitoring charts daily.
<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>Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. There is one qualified diversional therapist.</p> <p>The DT develops the weekly activity plans with the residents when able. The activities calendar/programme (Monday - Sunday) meets the individual physical, cognitive, intellectual and spiritual/cultural preferences of the residents. Small group activities and one-on-one time with residents were included in the programme. The DT advised that residents have input into the activities programme and links to the community are a focus of the programme.</p> <p>On the day of the audit a few residents participated in news reading. Van outings/scenic drives are planned weekly, and they are accompanied by the DT (with a current first aid certificate). Weekly van outings are planned on Sundays for residents in the dementia unit.</p> <p>Activities varied according to the residents' interest and include van drives, devotion, a debate club, music entertainers, walking group, exercises, visiting other aged care facilities (if possible) for inter-house games. The hairdresser visits regularly.</p> <p>The weekly activities are posted on noticeboards and emailed to family/whānau when required. The DT interviewed confirmed caregivers assist and support with weekend activities. The activity plans sampled were well-documented and reflected the resident's preferred activities and interests. The resident's activities participation log was sighted. The DT confirmed that the programme is flexible and can change and the focus is on resident input and choice into the activity's planner.</p> <p>This audit was conducted during Covid-19 level 2 guidelines and residents were engaging in a range of activities amidst restrictions of the ongoing pandemic. Relatives interviewed confirmed their satisfaction around activities offered and confirmed they are kept up to date throughout the Covid-19 restriction levels.</p> <p>Staff were observed interacting with residents in the lounge. Residents and families interviewed verbalised the activities provided by the service are adequate and enjoyable.</p> <p>Feedback on the programme is received through three-monthly resident meetings and annual satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	FA	<p>Files reviewed demonstrated that the long-term care plans were evaluated at least six-monthly (or earlier if there was a change in health status). Changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing, as sighted in resident files reviewed. Three monthly clinical review meetings were held with the</p>

comprehensive and timely manner.		EPOA/relatives and the resident, interventions records where progress is different from the expected goal. Changes are and new goals were updated on the long-term care plan. The GP reviewed the resident at least three-monthly. Other allied health professionals involved in the care of the resident provide input when required.
<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	The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Family/EPOA are involved as appropriate when referral to another service occurs. The service liaises closely with the need's assessment team. At the time of audit there was one example where a resident's condition had changed and awaiting reassessment to higher level of care.
<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>	FA	There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. There is a documented process to clean reusable protective eyewear. Chemicals were labelled correctly and stored safely throughout the facility. Safety datasheets and product use information was readily available. Staff have attended chemical safety training.
<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>The general manager oversees the maintenance programme and is available after hours when required. Maintenance requests are addressed in a timely manner. A monthly planned maintenance schedule is maintained. There is a maintenance book for staff to communicate with maintenance staff issues and areas that require attention. Maintenance and repairs are completed within a reasonable timeframe. There is a sufficient amount of equipment on site (wheelchairs and scales) to replace equipment sent off site for maintenance or repairs.</p> <p>Essential contractors are available 24 hours a day, seven days a week. Fire service monitoring are</p>

		<p>conducted by approved contractors. Electrical testing and annual calibration had been completed in August 2021. Hot water temperatures in resident areas are monitored monthly and corrective actions implemented where identified. The building warrant of fitness is current and expires on 1 June 2022.</p> <p>Regular refurbishment including carpets, drapes and paint work are included in the maintenance schedule. This is an ongoing project as required.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.</p> <p>The facility is a two-storey building. There are 12 studios upstairs (rooms 50-57) which are accessible by lift and four studio rooms (13 and 13a-15) accessible by stairs only, with corridors within each area wide enough and allow residents to pass each other safely. The remainder of the total of beds are located downstairs. There is sufficient space to allow the safe use of mobility equipment. Safety rails appear appropriately located. There is one sluice room located near the laundry.</p> <p>Forty-four spacious studio apartments with ensuites were verified at this audit as suitable to be used as double rooms for married couples. Advised that the service would only take up to 10 couples at a time.</p> <p>There is a lift between two floors with emergency exits to the carpark.</p> <p>There are two moderate sized outside courtyard areas with seating, tables and louvres and/or umbrellas for shade. Pathways, seating and grounds are well maintained. All outside hazards have been identified in the hazard register. There is a designated smoking area outside for residents that complies with relevant legislation.</p> <p>There is a library, TV area and seating in the foyer for quiet space when required. Resident rooms were labelled for ease of identification. The lounge area is designed so that space and seating arrangements provide for individual and group activities.</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</p>	<p>FA</p>	<p>All resident rooms have full ensuite. There are staff toilets and visitors' toilets around the facility. There are handbasins for handwashing and flowing soap, paper towels and hand sanitiser.</p>

receiving assistance with personal hygiene requirements.		
<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>All residents' rooms were of an appropriate size to allow the level of care to be provided and for the safe use and manoeuvring of mobility aids including hoists. Residents are encouraged to personalise their bedrooms. Two rooms each shared by a married couple were visually inspected and verified to be spacious enough for two beds, safe mobility and to deliver safe care. A further 44 spacious studio apartments with ensuites were verified at this audit as suitable to be used as double rooms for married couples. Each studio room is spacious and allows for two beds and room for chairs and mobility equipment.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has a large lounge which is used for group activities and entertainment. The dining room and other furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounge, library, dining room, and outside area and this was confirmed by staff interviewed.</p> <p>There is adequate space to allow maximum freedom of movement while promoting safety.</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>Caregivers assist with laundry tasks. The facility has a laundry that provides for personal clothing, linen and towels. There is a dirty to clean flow that staff could describe. The service has secure cupboards for the storage of cleaning and laundry chemicals. Chemicals are labelled. Material safety datasheets are current, displayed in the laundry and available in the chemical storage areas. There is a cleaning schedule for staff to follow.</p> <p>Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an</p>	FA	<p>Emergency systems are checked monthly including call bells, emergency lighting and fire alarms. The service has implemented policies, procedures and plans for civil defence, pandemic management and other emergencies. The service has an emergency civil defence box. Emergency lighting, gas heating, and a BBQ are available in the event of a power failure. A battery backup supplies power to the emergency</p>

<p>appropriate and timely response during emergency and security situations.</p>		<p>lighting. Staff stated that there were plenty of PPE available. The service has extra food and sufficient water supplies as per the local council civil defence requirements) available for use in the event of an emergency. Call bells were evident in residents' rooms, lounge, and toilets/bathrooms. Call bells were observed to be answered appropriately on day of audit. There were two call bells available in double rooms verified as part of this audit. There is at least one staff on each shift (including RNs and DT) with a current first aid certificate. There is an evacuation scheme approved by the New Zealand Fire Service (12 January 2007). Six monthly trial evacuations occur (last 6 July 2021). Security procedures are established. The property has a secure gate on exit to the property which is locked on dusk. Contractors to Kauri Lodge are required to identify themselves and sign a visitor's book.</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>General living areas and resident rooms are appropriately ventilated and heated. All rooms have external windows with plenty of natural sunlight. The residents and family interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months.</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 prevention and control programme is appropriate for the size and complexity of the service. The infection control and prevention officer is the clinical manager. A job description defines the role and responsibilities for infection control. The infection prevention and control committee are combined with the health and safety committee, which meets two-monthly. The programme is set out annually and directed via the quality programme. On the day of audit, Kauri Lodge was operating effectively under level two Covid-19 lockdown guidelines.</p> <p>Residents and staff are offered the annual influenza vaccine. Hand sanitisers are placed appropriately within the facility.</p> <p>Visitors are asked not to visit if unwell. There is QR screening and declarations in place for all visitors and contractors that visit the facility. Hand hygiene notices are in use around the facility and there are hand sanitisers strategically placed throughout both buildings. Family/whānau have been kept updated on visiting policies during Covid-19 risk periods. Residents and staff had been vaccinated if they have consented.</p> <p>Infection control audits are completed as per the audit schedule. The IPC plan is reviewed annually as part of the quality plan.</p>

		<p>Staff interviews confirmed residents and family/whānau education around IPC, particularly around Covid-19 risk.</p> <p>There are documented processes around cleaning equipment between use.</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 reports to the committee, management and facility meetings any trends and analysis of infections. The infection and prevention coordinator have access to an infection prevention and control nurse specialist from the DHB, microbiologist, public health, GPs, local laboratory and expertise from within the organisation.</p> <p>Covid-19 strategies have been implemented within the facility. PPE stocks are regularly replenished. Staff were observed practicing good hand washing techniques.</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>IPC policies outline a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team, and training and education of staff. Policies were reviewed and updated yearly. Covid-19 Guidelines are implemented for each alert level.</p> <p>Kauri Lodge has a Covid-19 Pandemic contingency plan in place. There were plenty of PPE stored and available.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to all staff, and she has attended external training for her role. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits and education</p>

<p>service providers, support staff, and consumers.</p>		<p>annually. Infection control is an agenda item on the full facility and clinical meeting agenda. There is regular education around Covid outbreak management to ensure staff are fully aware of protocols when lockdown levels change.</p> <p>Resident education occurs as part of providing daily cares.</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>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included in a register and the infection control and prevention coordinator completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the two monthly combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and trends are displayed.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility.</p> <p>There have been no identified outbreaks since the previous audit.</p> <p>Infection rates are reported to be very low.</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>There are policies and procedures on restraint minimisation and safe practice. The clinical nurse manager is the restraint coordinator and confirmed that the service continues to maintain a restraint-free environment. There are no residents utilising enablers. Training around restraint minimisation and challenging behaviour has been provided at least annually and last provided August 2021.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

No data to display

End of the report.