The Ultimate Care Group Limited - Rose Lodge

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Rose Lodge
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 October 2017 End date: 19 October 2017

Proposed changes to current services (if any): This provisional audit was undertaken on behalf of a prospective purchaser of the facility, The Ultimate Care Group. A manager from this service informed that if the purchase goes through, they expect to accept responsibility for the facility in December 2017.

Total beds occupied across all premises included in the audit on the first day of the audit: 26

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.

General overview of the audit

Rose Lodge is an aged care facility in Invercargill that provides rest home level care for up to 30 residents. The service is owned and operated by The Greenvale Group Limited and managed by a facility manager.

The facility is well maintained and positive feedback about the quality of care and services provided was provided by residents and family members.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner. An interview with the prospective clinical services manager was also undertaken.

This audit has identified three areas requiring improvement. These relate to the new staff orientation/induction programme, three specific aspects of staff training and medicine administration competencies.

Consumer rights

Services are provided that support personal privacy, independence, individuality and dignity, and staff were observed interacting with residents in a respectful manner. An interpreter service is available on request but has not been required.

Policies are in place to ensure residents are free from discrimination, or abuse/neglect. Residents and family interviewed reported that they are always treated with respect. During the audit, staff were observed offering choices and acknowledging individual rights and beliefs.

The service has links with a range of specialist healthcare providers to support best practice and meet residents' needs when required.

Completed adverse event reports showed that open disclosure is occurring. Staff provide resident and families with the information they need to make informed choices and give consent.

Residents and their families are provided with a copy of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights as part of the information portfolio given on a resident's admission.

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

Organisational management

The Greenvale Group Limited is the current governing body and is responsible for the services provided at the facility. A business plan and a quality assurance plan are documented and include a care philosophy, quality of care statement and business and quality goals for the service. Systems are in place for monitoring the services provided, including regular weekly and monthly

reporting by the facility manager to the governing body. The facility is managed by an experienced and suitably qualified manager who is a registered nurse.

A quality and risk management system is in place. This includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and staff, resident and family satisfaction surveys. Collection, collation and analysis of quality improvement data is occurring and is being reported to monthly quality meetings and to bi-monthly staff meetings, with discussion of trends and follow up where necessary. Meeting minutes are available for all staff to read. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. All aspects of quality management, including formal and informal feedback from residents and families are used to improve services. Actual and potential risks are identified and mitigated, and the hazard register is up to date.

A suite of policies and procedures cover the necessary areas to meet the standard and the needs of the service, are current and are reviewed every two years.

The prospective provider has a transition plan for the gradual implementation of their own systems and processes. This has been used successfully for previously acquired facilities and includes the introduction of their own policies and procedures and quality management systems.

There are human resources management policies and procedures, which are based on current good practice, to guide the system for the recruitment and appointment of staff. A comprehensive staff training programme ensures all staff maintain the competencies for their specific roles. A systematic approach to identify, plan, facilitate and record ongoing training supports safe service delivery. Annual individual performance reviews are completed.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster of senior staff on call out of hours. The prospective service provider has no immediate plans to change staffing levels.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Residents' needs are assessed on admission and used to provide individualised care plans. Files reviewed demonstrated that the care provided and needs of the residents are reviewed and evaluated on a regular basis, with input from the residents and their families.

Residents are referred to other health services as required after consultation with the doctor, registered nurse (RN), resident and family or support person.

Medications are prescribed appropriately, and accurate records kept. Administration of medications was safe and consistent with good practice.

Planned activities with a variety of entertainers, outings and group activities maintain residents' links with the community.

The kitchen was clean and well organised. Individual food preferences and specific dietary needs were catered for. The menu is reviewed by a qualified dietician every two years and meets the guidelines for nutrition for the older person.

The general practitioner, who was interviewed during the audit, expressed that the care the rest home staff deliver is of a high standard, and follows medical treatment recommended.

Safe and appropriate environment

Implemented policies guide the management of waste and hazardous substances. Contractors are responsible for many aspects of these processes. Protective equipment and clothing is provided and used by staff.

The building, plant and equipment comply with legislation and safety standards. A current building warrant of fitness was displayed. There is a preventative and reactive maintenance programme implemented.

The facility has been purpose built. All rooms are suitable for one resident only. Most are of a similar size, which is adequate for the provision of personal care. Two rooms share an ensuite, otherwise bathrooms and toilets are shared by all residents.

A communal lounge and the separate dining areas are spacious and maintained at a comfortable temperature. There is a family/whānau room which residents also use. Established gardens are in the safe paved, concrete and asphalt external areas.

Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite. Systems are in place to monitor and evaluate the effectiveness of both cleaning and laundry processes.

Emergency procedures are documented and displayed. Regular fire drills are completed and there are smoke alarms and a sprinkler system installed in case of fire. Residents reported a timely staff response to call bells. Staff implement the documented security procedures at night.

Restraint minimisation and safe practice

Restraint minimisation policies and procedures meet the requirements of the standard. The quality assurance meetings include any updates on restraint minimisation. Training on enabler and restraint use, and on the use of alternative strategies when appropriate, is provided. Staff were aware of the three types of restraints that have been approved for use at Rose Lodge. Restraint use is actively discouraged and there were no enablers or restraints in use at the facility at the time of audit.

Infection prevention and control

There is a documented Infection Control and Prevention Programme which meets required standards. This programme is reviewed annually. The infection prevention coordinator is supported by the registered nurse and facility manager. Information is reported at quality meetings. Staff are updated at regular staff meetings. Implementation of the programme, internal audits, and surveillance all aim at preventing and managing infections. Specialist infection prevention and control advice is accessed through the local district health board when needed

General practitioners are consulted regarding individual resident's infections and appropriate use of antibiotic is monitored.

Infection control surveillance is occurring. The numbers and types of infection are analysed and reported through all levels of the organisation

Education is held annually for all staff. Residents and family members are educated for specific practices and when visiting 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	43	0	1	1	0	0
Criteria	0	90	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Rose Lodge has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff were observed demonstrating respectful communication, providing options, and maintaining dignity and privacy. Annual education is provided for staff, this is due again in November. Residents and family/whānau members expressed that they felt their rights were being respected.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Admission agreements were sighted. Each resident or enduring power of attorney signs the agreement as part of the admission process. This includes consent for care/general treatment, outings, photographs and use of information. Additional consent is obtained on an as required basis, such as when a resident's needs change or additional medical/surgical treatment is required. Residents interviewed confirmed that they were given ample time to make

		informed choices and that their consent was obtained and respected. Family/whānau members confirmed that they were informed in a timely manner about what was happening with their relative. Staff were observed gaining consent for day to day care. Advance directive plans were discussed at admission and information given if asked for. Currently no advance directive plans were on files but the facility manager said any requests would be upheld. Discussion is held by the general practitioner around the resuscitation process and documented in the clinical notes.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	As part of the admission process all residents receive a copy of the Code and a brochure from the Nationwide Advocacy Service. Posters were displayed and spare copies of the brochures were available at reception. The activities coordinator arranged a speaker from the Advocacy Service to share information about the role of an advocate. Advocacy and support is part of the annual education programme for staff as sighted in the education plan.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Rose Lodge has open visiting but does ask that meal times are respected. Visitors are always welcome. Staff were observed to be flexible in accommodating individual family members and resident's requests. All family/whānau members said they felt welcome and as if they could visit at any time. The service has a van to provide regular outings, for example, to feed the ducks, shopping trips, and to visit other rest homes as part of an inter rest home bowling competition. This was observed on the activity planner in each resident's room and around the facility. Residents are encouraged to access their normal health care services in the community, such as dentists and optometrists.
Standard 1.1.13: Complaints Management	FA	The compliments, concerns, complaints policy and associated forms meet

The right of the consumer to make a complaint is understood, respected, and upheld.		the requirements of Right 10 of the Code. Information about making a complaint is in the information pack provided on admission and the admitting registered nurse talks about the complaints process with residents and family members, when present. Residents interviewed confirmed they can talk to a staff person or the facility manager if they have a concern. The complaints register was reviewed and showed that five verbally raised concerns have been addressed by the service provider as complaints for 2017. Documented action plans confirmed that required follow up and improvements have been made where possible and these have occurred within the timeframes specified in the Code. The facility manager who is responsible for the follow-up process noted that all have been satisfactorily resolved with the involvement of an advocate in one situation. Reports on the follow-up of concerns raised and compliments received were evident in staff and quality assurance meeting minutes. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	A copy of the Code was received and discussed during the admission process. Posters were displayed and extra copies of the Code brochure were available. Staff from the Nationwide Health and Disability Advocacy Service (Advocacy Service) spoke at a meeting for the residents earlier in the year about their services. The prospective providers own and operate 18 aged care facilities (refer Standard 1.2.1). They know and understand the consumer's rights.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and	FA	All residents have an individual room with personal belongings reflecting their culture and providing privacy. Staff were seen to be interacting with residents in a friendly and unhurried manner and this was confirmed in resident interviews.

independence.		Long term life style plans reviewed, included specific information related to maintaining residents' independence. For example, to have walking frames in reach to enable independent mobility. Religious and social needs, values, and beliefs were also incorporated. Files are kept securely in the nurses' station with the door shut when no one was in attendance. Residents interviewed stated that they felt safe and have not been subject to, or witnessed any signs of abuse or neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	At the time of the audit Rose Lodge had one resident who identified as Māori. The service has a Māori Health Policy with resources to guide staff including contact details for a range of Māori health providers and cultural advisors. In order to achieve partnership, participation and protection, whānau and iwi are consulted with to provide appropriate health and disability care services. Education, training and resources support the recruitment, retention and development of Māori staff. Rose Lodge fosters te reo Māori. The Māori Health Plan and associated documentation has been approved by local kaumatua.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents verified that they were consulted on their individual, ethnic, cultural, spiritual values, and beliefs on admission, and on an ongoing basis. Annually, a family input form is given to family/whānau to make any changes to information. All lifestyle plans reviewed reflected the personal preferences and individual requirements of the residents, with goals and interventions documented to ensure these were met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family interviewed stated that they felt safe and were free from any type of discrimination or exploitation. Staff demonstrated a clear understanding of what would constitute

		inappropriate behaviour and the processes they would follow should they suspect this was occurring. The policies and procedure manual verified this.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Rose Lodge has a professional network with a range of external specialist services and allied health professionals. These include wound care specialists, mental health services for the elderly, physiotherapists and dieticians. These are a source of additional knowledge and expertise to supplement their own skilled staff. The RN reported that they receive management support for external education, which is then passed on to other staff at staff meetings. Articles of interest were given to staff and discussed. The general practitioner interviewed confirmed that the service sought prompt and appropriate medical intervention and were responsive to medical requests.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Each resident's file reviewed contained written documentation of family contacts, and confirmation of contact in the progress notes. Adverse event forms demonstrated open disclosure and effective communication with residents and their family/whānau. Family members stated that they were informed in a timely manner of any changes in their relative's health status. Interpreter services are available through the Southern District Health Board. Although the service has not been used contact details were available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	A philosophy of care describes how self-identity, personal powerbase and the provision of security and a sense of belonging will be preserved. A separate quality of care document details values of the service. The business plan, which is current, details how a strengths, weaknesses, opportunities and threats (SWOT) analysis has contributed towards developing a set of goals and objectives that cover issues such as

		reputation, occupancy, budget, environment, staff training and innovation. Associated operational plans are detailed in these documents. Examples of weekly and of monthly reports to the owner/board were sighted and show a cross-section of key performance indicators are being monitored. Rose Lodge is managed by a facility manager who is a registered nurse and has been in the role for approximately two years. During interview she expressed knowledge of the sector, regulatory and reporting requirements and her personnel folder showed she is maintaining currency of a range of professional development topics. The owner/manager, who has managed aged care facilities for more than 20 years, confirmed that she is very satisfied with the skills, knowledge and performance of the facility manager. This was further evident in the recently completed performance appraisal, which notes how the facility manager is upholding the responsibilities and accountabilities defined in her job description and individual employment agreement. The facility manager described her passion for caring for the residents under her care. All residents at the 30 bed Rose Lodge facility receive rest home care and support services under the Aged Related Residential Care (ARRC) agreement. Twenty six people were in residence on the first day of audit, one of whom has been admitted for short term carer relief. A twenty seventh person is currently in the local public hospital. An interview with the clinical manager of the prospective provider, the Ultimate Care Group, was undertaken. The Ultimate Care Group is one of the largest residential aged care providers in New Zealand owning and operating 18 facilities nationwide. It has its own board and governance structure. Well established universal quality management, policy and procedure and service delivery systems are reportedly operating within its services. These have already been confirmed as meeting the requirements of the Health and Disability Services Standards during audits of other Ultimate Care Group facilities. The manager confirmed that with the support of other Ultimate Care Group team members they would progressively introduce these systems and their associated documentation, which they have found to be successful in their other aged care services. With such a long association in delivering aged care services the team understand consumer rights and what needs to be adhered to. The manager noted that there were no immediate plans for any structural or environmental changes of Rose Lodge and that a

		transitional plan proven to work in other facilities that they have purchased would be used. This commences with a three month timeframe from when the sale is finalised. Staffing levels would continue as it currently is with no immediate plans for change, although reviews will be ongoing as they work through the transition period and beyond.
Standard 1.2.2: Service Management 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.	FA	A registered nurse, who also works at the facility, takes over a set of delegated responsibilities during any temporary absence of the facility manager. The owner/manager does not take planned leave at the same time as the facility manager, will ring in each week to check on how things are being managed and is available to provide additional on call support when required. Facility managers of other facilities of the current owner, including one that is local, are also available to assist. All staff, including the registered nurse, reported the current arrangements work well. Significant routine meetings, such as quality assurance and staff training, are postponed and rescheduled until the facility manager returns.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The quality assurance and risk management systems reflect the principles of continuous improvement in all areas of their implementation. A quality management/certification policy and philosophy describe the roles of the quality coordinator/facility manager, the quality assurance committee and the audit programme. Monthly quality assurance meetings include the facility manager, registered nurse, enrolled nurse, health and safety officer, a care assistant representative, the infection control officer, cook, cleaner, activities coordinator and maintenance person. Meeting minutes sighted report on the management of complaints, incident and accident reporting, health and safety, internal audit management and reporting, resident/family satisfaction and staff satisfaction surveys, infection surveillance reporting, significant resident issues and any restraint management. Specific resident related issues that have been discussed for improvement purposes have included discussion on topics such as wound management, resident behaviour/mood changes and falls. Residents' meetings are held monthly and staff meetings are two monthly. All meetings are minuted. Policies and procedures, which cover all aspects of the service and all

		contractual requirements, are categorised under topics and alphabetically ordered. All sighted were current. The document control system is described in a policy document, which details formatting requirements and the document approval process. It also notes that approved documents are to be reviewed at least every two years and as necessary. The health and safety officer and the infection control nurse provide separate reports for the quality assurance meetings, where they are further discussed for quality improvement purposes. Staff reported their involvement in quality and risk activities through undertaking internal audits, reading and signing meeting minutes, keeping the registered nurse and/or the facility manager informed when things happen and completing the necessary forms such as incident reports. Relevant corrective actions are developed and implemented at the source, whether this is from an internal audit outcome, complaint follow-up or an incident report, for example. Patterns of recurrence are identified following the analysis of data by the quality coordinator and/or the quality assurance team. Resident/family surveys are completed annually with the last survey showing overall satisfaction. Three suggestions identified during the last staff survey were followed through at the staff meeting and with the relevant staff members. An annual internal audit schedule for 2017 was sighted, as were tools used during the different audits. A form for completion in the event of any identified corrective action is in place, as is a re-audit reporting form. Examples of these being used were sighted as were reports in quality assurance meeting minutes of progress with corrective actions. A comprehensive risk management programme defines the risk management process, identifies the stakeholders and describes their responsibilities for each category of potential risk. Categories include residents, staff, property/environment, financial, organisational/governance and 'other'. The risk management plan demonstrates that risks are identified monitored and reported at the relevant level of the organisation and mitigation strategies are developed accordingly. There is a risk register, which shows consistent review and updating of risks, risk plans and the addition of new risks. The manager attended training in the Health and Safety at Work Act (2015) requirements and has implemented relevant requirements.

Standard 1.2.4: Adverse Event Reporting 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.	FA	Procedures describe essential notification reporting requirements and the facility manager was aware of these requirements in regard to coroner enquiries, staffing and employment issues, notifiable diseases and significant events, for example. A section 31 had been completed for a fire within the facility earlier in 2017. Related correspondence was sighted with the report acknowledged. A sudden death had also been reported. An employment issue that arose had been managed satisfactorily. Adverse and near miss events are documented on an accident/incident form, as per the service provider policy and procedures. The registered nurses were aware of the need to record pressure injuries on these forms. A sample of incident forms reviewed show these had been fully completed and that incidents are investigated, action plans developed and actions are followed-up in a timely manner. Open disclosure was evident. Adverse event data is collated, analysed and reported through the monthly quality assurance meetings with summaries presented at the two monthly staff meetings. Related records and meeting minutes reviewed showed discussion in relation to trends and corrective action plans developed when indicated. Improvements have been made for individual residents and at the wider rest home level with an example being the de-cluttering of rooms to reduce the number of falls, which the facility manager reported had been successful. Staff interviewed confirmed they receive follow-up from any incident forms they complete.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	Human resources management policies and procedures were reviewed. These reflect good employment practice and relevant legislation and are being used to guide human resources management processes. A sample of staff records that were reviewed confirmed the service provider's policies are being consistently implemented and records are systematically maintained. Position descriptions in staff files were current and defined the key tasks and accountabilities for the various roles. Documentation sighted showed that the recruitment process includes a formal application process, referee checks, police vetting and validation of qualifications, where required. Annual staff performance appraisals were up to date in all staff files reviewed. Staff reported that they are well

		supported by the facility manager and the registered nurse. The facility manager provided records of current practising certificates for the registered and enrolled nurses, the local GPs who provide services to Rose Lodge, the podiatrist and the pharmacists from the pharmacy that the service provider uses. There is a need for the recently employed enrolled nurse to undertake interRAI training as there are insufficient trained staff for this role (Refer 1.3.3). A lack of registered nurse hours for interRAI assessments has meant that nearly half of residents have not had a reassessment completed within the required timeframe. Following a conversation with the portfolio manager, the facility manager has drawn up a documented plan of action to manage the current backlog of interRAI re-assessments. The need for additional interRAI trained staff has been included in a corrective action related to staff training as around 50% of residents do not have a current interRAI assessment and no further training is available in the region until 2018. Staff orientation checklists are in staff files. The checklists do not cover all of the topics as expected, not all are being completed by new staff and there was a lack of evidence of staff receiving adequate orientation. Although the prospective provider informed they will be introducing their own orientation programme a corrective action has been raised to address the identified shortcomings. Mandatory training requirements are defined, and internal staff training is scheduled to occur on a monthly basis throughout the year. Most training topics are complemented by competency assessments. Staff reported they have access to external training courses if they want. The training topic schedules for both 2017 and 2018 were sighted. Care staff have either completed a New Zealand Qualification Authority education programme, are being supported with it or are being encouraged to commence such a programme. The required topics of the provider's agreement with the DHB are included within the internal training programme with six monthly repeats. Individual staff education records were sighted, as were attendance lists for the different monthly staff training sessions. It was noted that the activities coordinator has not completed training that meets the requirements of the ARRC agreement and the cleaner has not yet completed chemical safety training. These

		shortcomings require corrective action.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A staff number and skill mix policy and procedure describes the different circumstances that determines staffing levels and skill mixes in order to provide safe service delivery. The facility manager described how she adjusts staffing levels to meet the changing needs of residents and provided examples of changes made to staff numbers to accommodate such circumstances. Even when not on call, the facility manager informed that she still makes herself available unless out of the city. Review of eight weeks of the roster demonstrated all staff absences had been filled with a relief person known to the residents, that the person responsible for medicine management was identifiable, as is a weekend activity person, and that the most senior person on duty was marked for each shift. The facility manager noted that although most care assistants have their first aid certificate, she ensures that at least all those with a medication competency have an up to date one, as this means that at least one person on every shift will be competent in first aid. An afterhours on call roster is in place and staff report that good access to advice is available whenever they need it. Care staff reported during interview that adequate staff were available and that they are able to complete the work allocated to them. They stated they work as a team that if they need more staff there is always an additional person they can call in and when used this has never been questioned. Residents and family interviewed were satisfied with the staffing levels and felt the needs of residents are being met. Usual staffing numbers were in place during the audit and the auditors observed that a relaxed atmosphere remained throughout, residents were approached in passing to check on how they were and any requests, such as the need for hearing aid batteries, were attended to. Observations during the audit and review of the roster sample confirmed adequate staff cover are being scheduled. A summary of the review of the rosters is that there is a minimum of three staff on all morning shifts, two on afternoon shifts and two on night shifts. At times, duties will cross with others and there will be one or more additional care assistants to these minimum figures. In addition, the facility

		manager works all day Monday to Friday, the registered nurse works six hours for four days and four hours on a fifth, the enrolled nurse provides additional out of hours clinical cover for four hours on two afternoons and five hours for two days of every second weekend and an activities person works five and a half hours Monday to Friday. There is handover time built into the shift timeframes. Auxiliary staff such as the cook, maintenance person and cleaner work as per their individual rosters.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All components of the residents' records reviewed included the residents' unique identifier. Files were well organised and fully integrated, including information such as wound care plans, allied health visits, laboratory results, and medical files. All records were kept in the nurses' station where the door was shut if no staff were present. Archived material was available and stored securely in a filing cabinet. Detailed progress notes were maintained and updated each shift. Staff signatures and designations were sighted. Countersigning of care assistants' notes were undertaken by the RN.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter Rose Lodge after being assessed by the local Needs Assessment and Service Coordination (NASC) Service and having had a level of care determined. Prospective families are encouraged to visit the facility and receive written information about the service in an Information Portfolio. This includes information on the Code, advocacy service, how to make a compliment/complaint, informed choice and consent, service fee, family information, resident information and a welcome letter. Family/whānau expressed during an interview that this information was helpful and the admission process was streamlined and maintained their privacy by taking place in a family room.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition,	FA	Exit, discharge or transfer are discussed with the general practitioner, facility manager, RN, family/whānau and resident. A copy of the care plan, medication chart, resuscitation status, and relevant clinical and progress

exit, discharge, or transfer from services.		notes as necessary, were sent with the resident. This is followed up by a verbal handover via the phone giving time of arrival. Family verified they felt well informed during the transfer of the resident.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	Medications are supplied using the robotics medication roll system. These are reconciled against the medication chart, by the RN or EN on duty when they arrive. They are then entered into the Medimap system as a record of delivery. Each of the fourteen medication charts reviewed contained a current photograph and their allergy status was recorded. All medications were appropriately charted. Discontinued medications were signed by the general practitioner and pro re nata medications had indications for use. A medication round observed was performed in a safe manner. The senior care assistant wore an apron indicating she was unavailable. Staff had a clear understanding of the responsibility of adverse reactions, and where to obtain information on the medications. All medications are stored in a locked cupboard in a methodical way and evidence of stock rotation was observed. Controlled drugs were locked in a metal cupboard and administered by two staff. The controlled drug register had accurate balances and evidence of weekly and six monthly stock balances. Temperature of medications fridge are recorded on a daily basis and all eye drops are dated and within the use by period. At the time of audit, no residents were self-administering their medications, but policies are in place should this occur. There is a register of medication competent staff which is up to date. At the time of the audit an updated register was being formulated around the competency of using the Medimap system. Five staff still had to complete the competency for the Medimap system.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met	FA	Food service is provided on site by a cook and kitchen team who have completed training in safe food handling. Residents complete a nutritional profile on admission which details any

where this service is a component of service delivery.		allergies, likes/dislikes, special nutritional needs, and if modified cutlery is required. This information is sent to the kitchen who writes it in a book, which is checked when serving meals. The menu is divided into summer and winter time frames and within that is a five-week rotating menu providing a range of nutritious meals. The menu has been reviewed by a qualified dietician as being in line with recognised nutritional guidelines for older people; this was sighted. On inspection the kitchen was clean, tidy and well maintained. Temperatures of both food and fridge/freezers were recorded at recommended times and were within the expected limits. Food stored in the fridge was covered and dated with meat stored below other food. Dry goods in the pantry were stored appropriately with dated containers and evidence of stock rotation was seen. Currently there are six diabetics having their nutritional needs meet. A puree meal sighted was of the correct consistency and served in an acceptable manner. The meal time observed was calm, unhurried and residents stated they were enjoying the home style meals.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, then NASC is notified and support is offered to help the family/whānau source an appropriate facility. Should a resident's condition change to needing a higher level of care then a referral is sent to NASC for reassessment and family/whānau are assisted to find a suitable placement.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is gathered using a range of nursing assessment tools such as pain scale, falls risk, skin integrity, pressure risk (Waterlow) and nutritional needs. Cultural, spiritual values and beliefs form part of a questionnaire given to family/whānau to complete. This information is used to develop the lifestyle plan which is developed within three weeks of admission.

		Currently nearly half of the residents have had an interRAI reassessment completed within the required time frame. At the time of audit, there is only one interRAI trained RN. Discussion has been had with interRAI, a member of the Older Persons' Health team, and the facility manager. A documented plan of action has been developed to manage the backlog of assessments. A recently employed EN is to commence training at next available opportunity (2018). A calendar has been formulated to address the issue designating specific time for working on interRAI. This issue has been raised for corrective action under 1.2.7.5 in relation to staff training.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Residents' files evidence service integration with medical, nursing, allied health professionals and wound management notes in an ordered fashion within the files. Resident lifestyle plans were developed within the recommended time frames. Resident focused goals were measurable and achievable. Six monthly evaluations were current and amendments made to interventions as required. Changes to care are relayed to other staff at verbal handover, in progress notes and in short term care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The RN and EN were available to give support and guidance to care assistants which was observed at handover. Before staff finish their shift, they report back to the RN any relevant information, to be handed on to the next shift. During interviews with residents they expressed that they were happy with how their needs were meet. The general practitioner interviewed reported that medical input is requested in a timely manner, medical orders were followed, and that the residents receive a high standard of care.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs,	FA	Although the activities coordinator has no formal training she has been in the role for many years and provides an interactive and interesting programme. (Refer criterion 1.2.7.5). Residents' current and past interests

age, culture, and the setting of the service.		are collated on admission and individual activity plans are formulated with measurable goals. Documentation is via a tick chart and monthly entries in the progress notes. There is a driving safety plan for when the facilities van is used for outings. Inter-rest home activities include a bowling competition and shared afternoon tea. Activities are displayed on the monthly planner observed in residents' rooms and on notice boards throughout the facility. Activities include newspaper reading, bowls, pampering sessions, library, walks, shopping trips, happy hour and entertainers. Residents interviewed expressed that the activities programme was stimulating and enjoyable. The activities coordinator was on annual leave, so an interview was unable to be undertaken.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' lifestyle plans are reviewed six monthly or as a resident's needs change. Where progress is different from expected outcomes adjustments are made to the interventions. Residents are evaluated every shift with staff reporting to the RN changes from the usual patterns of behaviour. The RN reported that short term care plans are used for such things as infections or wounds and were assessed weekly or sooner if medically required. When necessary they are transferred to the long term care plan if not resolved within six weeks. This was observed in a resident's file.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	If the need for other services is identified the general practitioner or RN will complete a referral to seek specialist provider assistance. During the interview with the RN examples were discussed and forms reviewed for such services as physiotherapy, dietician, and wound specialist nurse. Family/whānau are kept informed during the process. Residents are free to choose the house doctor or maintain care under their family physician.

Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances were in place. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal. The manager reported how general waste is placed in a skip and removed by a contractor on a fortnightly basis. Recyclable cardboard is collected by a contractor for disposal, while other recyclables and green waste are collected into relevant dedicated bins for local council collection and private contractor removal respectively. The various bins were sighted. Doors to the areas where chemicals are stored were secured and containers were labelled. Appropriate signage is displayed where necessary. An external company is contracted to supply the chemicals and cleaning products and to provide relevant staff training. Material safety data sheets were available. Personal protective clothing and equipment including goggles, gumboots, masks, plastic aprons, gloves and over socks for when using the gumboots, is available. Staff were observed using such items during the audit.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness expiring 17 February 2018 is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the facility manager and observation of the environment. External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible bathrooms and toilets throughout the facility. A shared ensuite, with a shower and a toilet, sits between two residents' rooms. A separate shower and toilet is in one other bathroom; another two have a shower only and there are four other single toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories, such as shower chairs, are available.
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	All residents have their own room. Rooms are of sufficient size to enable residents and staff to move around within their bedrooms safely. One room that is generally used for residents going in for respite care, or carer relief support, is smaller than the rest and an adjacent one larger. All other rooms are of the same size. A feedback process identified safety concerns arising from an excess of 'clutter' being in some residents' rooms and the situation was remedied. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids and wheel chairs. Residents and family/whānau reported the adequacy of bedrooms.
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	The dining and lounge areas are spacious and enable easy access for residents and staff. Communal areas are available for residents to engage in activities. Most activities are undertaken in the residents' lounge. Residents were observed to be enjoying the conservatory. A separate family/whānau room is available if people want a small private area. Overall, the furniture is appropriate to the setting and residents' needs. It is arranged in a manner which enables residents to mobilise freely.
Standard 1.4.6: Cleaning And Laundry Services	FA	All laundry, including residents' personal items, is undertaken on site by care assistants in a dedicated laundry. Some family members have

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		requested to launder specific items. Residents and family interviewed reported the laundry is managed well. There was no evidence of laundry related concerns having been raised in the complaints register. The laundry is set up to facilitate a dirty to clean flow and the documented laundry procedures include a description for the handling of soiled linen. A housekeeper, who was interviewed about her role, is employed Monday to Friday. Care assistants complete minor cleaning duties on Saturday and Sunday. One other person is employed for deep cleaning duties and the owner/manager noted that this system is working well. Chemicals were stored in a lockable utility cupboard and were in appropriately labelled containers. Surplus/bulk supplies were in an external locked garage that is also labelled. Relevant cleaning and laundry schedules were sighted. Cleaning and laundry processes are monitored through the internal audit programme. Records of these showed that an unsatisfactory result earlier in the year had meant it was followed up by a re-audit. Results of the re-audit showed the requirements are now being met.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and were known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 11 May 1994. Copies of the reports from six-monthly trial evacuations are sent to the New Zealand Fire Service. The most recent of these was on 2 October 2017. New staff orientation includes fire and security training. Staff confirmed their awareness of the emergency procedures. Gas cooking facilities are available as are additional blankets and hot water bottles for use in an emergency. Additional food and water supplies, torches and basic equipment for use in the event of a civil defence emergency are available for a full contingent of residents and for staff. Emergency lighting is regularly tested. A separate health and safety infection control box has been prepared and its contents are also checked

		six monthly. The latest checks were undertaken in May 2017. A call bell system that includes an urgent assistance option is installed and was tested as operating satisfactorily during the audit. When pushed, a small red glow lights up above the relevant door. In addition, a digital display notes the whereabouts of the bell alert staff to residents requiring assistance. Call system audits are completed six monthly. Residents and family members reported staff respond promptly to call bells and this was evident when the system was tested during the audit. Appropriate security arrangements are in place. Windows have security latches in place. The front door is locked when there is no longer any staff at the front desk and the remaining doors are locked before nightfall. Doorbells are installed for use by after-hours visitors. Afternoon shift staff set the alarms that alert staff to a person entering the facility via external doors.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas have external windows that can be opened, with those closer to ground level having security latches in situ. Electric night store heaters are in all residents' rooms, in hallways and throughout the building. A recently updated heat pump is installed in the lounge area and electric fan heaters are in all shower rooms. Despite changeable outdoor temperature, areas were warm and well ventilated throughout the audit. Residents and families confirmed the facility and the rooms are maintained at a comfortable temperature. Monthly records of a sample of temperatures from different areas are within recommended levels.
Standard 3.1: Infection control management 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.	FA	The facility manager was interviewed because infection prevention and control nurse (IPC) was unavailable. The facility manager gave an overview of the IPC programme. A job description was sighted and described responsibilities of the IPC role. The position is held by a senior care assistant with a nursing history. Oversight and support are supplied by the RN and facility manager. Further support is available from the local

		DHB. The facility's policies and procedures, and infection control manual were detailed and demonstrated a safe and effective plan for managing infections in the facility. The manual included definitions, procedures and guidelines to identify infections, sharps management, and information for staff related accidents such as spills and needle stick injury prevention. Infection data is reported to facility manager monthly and is presented at quality meetings and quarterly to the board. The infection prevention and control programme is reviewed annually by the board and signed off. Visitors are advised by signage at the main entrance to refrain from visiting if they are unwell. Staff who come to work sick are sent home and unwell residents are encouraged to remain in their rooms.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	All staff receive annual infection prevention training including hand hygiene, cleaning and standard precautions. The IPC nurse receives training through study days through the DHB. This information is passed on to staff during further training sessions. The infection prevention and control programme is audited annually and recommendations from the IPC nurse are implemented. Additional support and advice is available from the infection control team at the DHB, the community laboratory and the general practitioner.
Standard 3.3: Policies and procedures 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.	FA	Documented policies and procedures are in place to minimise and manage infection in the facility. They reflect current best practice and meet standard requirements. Personal protective equipment is available and was in use during the audit. Hand sanitisers are placed around the facility.
Standard 3.4: Education The organisation provides relevant education on infection control	FA	The IPC nurse provides training to all staff on an annual basis. The orientation programme for new staff includes basic infection and

to all service providers, support staff, and consumers.		prevention information. Education with the residents is on a one to one basis for such things as hand hygiene and cough etiquette.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities of this size and scope. Infections monitored and analysed on a monthly basis include eye, ear/nose/throat, urinary tract, upper and lower respiratory tract, and skin. A detailed form is completed for each infection including information on type, area of facility, date of onset, contributing factors, when the GP was notified, and if a specimen was sent. If a positive result, what organism, type of medication charted, commencement/completion dates, and post treatment review. A copy of this data is kept in residents' files for using to make changes to lifestyle plans. This information was then graphed, analysed and compared to other data in the same month and same time of year. Rates are calculated according to bed occupancy. Results were communicated to staff at staff meetings and quality meeting. Recommendations are discussed and implemented as appropriate.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures that support the minimisation of restraint are being implemented. These documents include definitions of restraint, the voluntary nature of enabler use and the procedures to be followed in the event of any enabler or restraint use, including assessment, application, monitoring, recording, review and evaluation. The quality assurance meeting agenda has an allocated time for discussion on any restraint use. During interview, staff demonstrated a sound knowledge and understanding of enabler and restraint use and talked of de-escalation. They stated that three types of restraints have been approved for use at Rose Lodge, with these being lazy boys, lap belts and bedrails. Restraint is reportedly only used as a last resort when all other options have been explored. The facility manager/restraint coordinator confirmed there are not currently any enablers or restraints in use at this facility. Staff training

		on restraint is provided during orientation, and every two years thereafter. Records sighted showed that the most recent training was provided in late September 2017.

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	The new staff orientation programme policy and procedure was sighted. Staff reported during interview that the orientation process does not seem to be long enough, or comprehensive enough for new staff, especially if they are new to the industry. Staff records reviewed showed that four of seven files either did not have an orientation checklist, or it was incomplete. However, performance review reports written three months after new staff had commenced were evident in the reviewed staff files. The list of topics in the orientation programme checklist does not cover all of the essential components expected for an aged care service and does not clearly	An orientation/induction plan is in place for new staff; however, this does not cover all of the essential components required for aged care service provision and is not ensuring that all new staff commence with the knowledge and skills required for their role.	The orientation/induction plan is more comprehensive and all aspects signed off to demonstrate that new staff have been oriented to the essential components of the service. 180 days

		demonstrate how they link to the required core competencies. During interview with the prospective clinical manager it was confirmed they would be using their well-established orientation programme should the sale proceed.		
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	A comprehensive internal training programme and series of competency assessments, as well as external training opportunities, are available to all staff. There are however two specific areas that are not meeting expectations. Despite the facility manager requesting that the chemical supplier representative provide chemical safety training to the cleaner, who was employed approximately six months ago, this has not yet occurred. Also, the person providing the activities programme has not commenced training that enable her to be skilled in and accountable for assessment, implementation and evaluation pf social, diversional and motivational recreation programmes for residents, as required in 16.5c iii of the ARRC agreement. There are also insufficient registered/enrolled nurses trained in the interRAI assessment programme, which is causing a backlog of resident reassessments (refer to 1.3.4).	A cleaner who has been working at Rose Lodge for six months has not yet undertaken chemical safety training. The person responsible for the activity programme has not undertaken, or commenced, training that would enable her to be skilled in and accountable for assessment, implementation and evaluation pf social, diversional and motivational recreation programmes for residents, as required in 16.5c iii of the ARRC agreement. There are insufficient interRAI trained registered/enrolled nurses to enable residents' assessments/reassessments to be undertaken within required timeframes. .	Specialist health and safety and contractual training requirements, such as for cleaning staff and the activities coordinator, are completed and additional staff with interRAI assessment skills are required. 180 days

Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	Medications are checked against the medication chart and checked into Medimap on arrival by the RN or EN. A medication round was observed and carried out in a safe manner. Stock and medication rolls were stored in an appropriate locked cupboard. The medication trolley was locked when not in use. The facility was introducing an updated competency to include the use of a new electronic system. At the time of audit five staff had not completed the Medimap competency and signed the competency register.	An electronic system has been introduced for medicine management. As a consequence, a new medication competency process has been implemented. At the time of the audit, the medicine management competencies of five staff were still to be completed.	Medimap medicine management competencies for all staff are completed. 90 days

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, these 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.