Heritage Lifecare Limited- Chiswick Park Lifecare

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:	Heritage Lifecare Limited
Premises audited:	Chiswick Park Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 August 2018 End date: 2 August 2018

Proposed changes to current services (if any): Purchase of facility

Total beds occupied across all premises included in the audit on the first day of the audit: 40

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

Chiswick Park Rest Home provides rest home and hospital level care for up to 51 residents. The service is operated by the Oceania Group and managed by a business care manager and a clinical manager. The facility is to be purchased by Heritage Lifecare Limited (HLL). A representative from HLL was on-site during the audit. Residents and families spoke positively about the care provided.

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, management, staff, and a general practitioner.

This audit has resulted in no areas requiring improvement.

This facility is one of several being purchased at this time by Heritage Lifecare Limited (HLL) following the purchases of 16 other facilities since late 2017. HLL is a national provider with senior staff experienced in rest home, hospital and dementia level services. The HLL National Manager Clinical and Quality reported in June 2018 that HLL have a senior project team managing the transition of each new facility to HLL processes over a period of six months. The Chiswick Park management have been informed of the purchase date and the transition plans by HLL management. The transition will include the changeover to HLL; infrastructure support, policies, procedures and processes, and information technology systems. Workshops will be held for Chiswick Park staff as part of the transition plan.

Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Staff interviewed demonstrated good knowledge and practice in relation to respecting residents' rights in their day to day interactions. Advocacy services are readily available and contact numbers are accessible. Interpreter services are available if required.

Written informed consents are obtained from the resident, family/whanau, enduring power of attorney (EPOA) as required. Signed consent forms were sighted in all residents' records reviewed. Staff provide residents and families with the information they need to make an informed choice and give consent.

Open disclosure and effective communication is encouraged by staff and the contracted general practitioners (GP) or nurse practitioner (NP) for all incidents and accidents or any untoward events.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with family and a range of specialist health care professionals to support best practice and meet resident's needs.

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

Organisational management

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

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

All current resident information is collected in an integrated record folder and stored in a safe place. Records were current and up to date. Records are archived and can be retrieved when required. Residents' information is not accessible to unauthorised people.

Continuum of service delivery

Pre-admission information clearly and accurately identifies the services offered. The service agreements are signed by the resident, family and/or enduring power of attorney on admission to the service. The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed.

Residents` needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff. The service has nine general

practitioners and one nurse practitioner available to provide medical care for the residents. On call arrangements for support from senior staff are in place. Shift handovers and communication books guide continuity of care.

The registered nurses completes the person-centred care plans which are individualised, based on a comprehensive and integrated range of clinical information including the pre-admission interRAI assessment. Evaluations are completed six monthly on all aspects of the care plan following the interRAI re-assessment. Short term care plans are developed to manage any new problems that might arise. Residents/representatives/families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided was of an adequate standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers and a current interRAI assessment also completed prior to transfer.

The service has a planned activity programme implemented by the activities coordinator and overseen by a diversional therapist. Residents are encouraged to maintain links with family/whanau and the community. A facility van is available for outings.

A safe medication system was observed at the time of the audit. Medications are administered by registered nurses and senior healthcare assistants (checkers) all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery and this is supported by a chef and kitchen staff with food safety qualifications. The menu plan is reviewed by the organisation's registered dietitian. The system is well organised and meets all food safety standards. Residents and family members interviewed verified satisfaction with meals.

Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite/offsite and evaluated for effectiveness.

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

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Five enablers and three restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

The infection prevention and control programme is appropriate for this service. The programme is implemented and reduces risk of infections to residents, staff, family/whanau and visitors. The policies and procedures reflect current accepted good practice.

Relevant education is provided for staff and when appropriate the residents. The infection control nurse completes a monthly surveillance programme where data is collated, analysed and trended with previous data and organisational data. Where any trends are identified actions are implemented to reduce infections. The infection results are reported at the staff and quality meeting.

There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice can be accessed from the DHB, microbiologist, physician and the general practitioners. The programme is reviewed annually.

Summary of attainment

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

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

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The organisation 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 interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and choices and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training as was verified in the training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Systems are in place to ensure residents and where appropriate their family/whanau are provided with appropriate information to assist them to make informed choices and to give informed consent. The registered nurses and health care assistants interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical records reviewed showed that informed consent has been gained appropriately using the organisation`s consent forms. Advance care planning, establishing and

		documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented as relevant in the resident's individual record. Residents interviewed confirmed they have been made aware of and understand the informed consent processes and that appropriate information has been provided. Staff were observed to gain consent for day to day care. The GP interviewed understands the obligations and legislative requirements to ensure competency of residents as required for advance directives and reviews undertaken six monthly. Reviews of health status are documented on the appropriate form available and retained in the individual resident's record.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process residents are given a copy of the Code which also includes information on the nationwide advocacy service. Pamphlets and posters related to the advocacy service are displayed and available in the facility. Family members and residents spoken with were aware of the advocacy service and how to access this and their right to have support persons.
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	Residents are assisted to maximise their potential for maintaining independence and links with family and friends in the community by attending a variety of organised activities, visits, shopping trips, entertainment and or activities. The facility welcomes visitors and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealing with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.

		The complaints register reviewed showed that eight complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The business care manager (BCM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There has been one complaint received from an external source since the previous audit. This was from the Health and Disability Commissioner (HDC). A review of records confirmed that requests for documentation has been provided within specified timeframes. The complaint is on-going.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed report being made aware of the Code and Nationwide Health and Disability Advocacy service (Advocacy Service) through the registered nurse as part of the admission information provided and the discussion with staff. The Code is displayed in all service areas together with information on advocacy services, how to make a complaint and feedback forms. The prospective provider interviewed has an excellent understanding of consumer 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 independence.	FA	The independence, dignity and respect policy reviewed includes the philosophy of maintaining the residents` independence and encouraging individuality. The sexuality and intimacy policy provides guidance for staff on residents' rights as well as staff responsibility for the safety of residents. Guidance on managing inappropriate behaviour is included. The process for accessing personal information is detailed. The family/whanau members and residents interviewed reported that they are treated in a manner that shows regard for their dignity, privacy and independence. All residents have a single room and interviews with residents/family are held in private. There is also a lounge with a telephone for residents` use or meetings. A church service is held

		weekly and residents if able can attend church in the community. The residents` records reviewed indicate that residents receive services that are responsive to their needs, values and beliefs of culture, religion and their ethnicity. Residents and family members reported a high level of satisfaction with all levels of care they receive. As observed on the day of the audit and confirmed with review of the individual resident's records randomly selected residents receive services appropriately to meet their needs. No concerns in relation to abuse and neglect was reported from residents, the GP, family and/or staff interviewed. Comments made reflected a positive atmosphere from family.
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	A policy is available for the identification and planning of care needs for Maori residents. This includes a range of cultural issues/considerations for staff to be aware of to ensure the provision of culturally appropriate care to Maori residents. Family/whanau input and involvement in service delivery is sought if applicable. When required, other supports are accessed. Best practice principles are identified. A commitment to the Treaty of Waitangi is included. Staff are provided with training on the provision of culturally appropriate care. The organisation has a Maori health plan. There were two residents who identified as Maori and respect for their individual cultural needs were maintained and tikanga practices adhered to. Healthcare assistants interviewed were aware of meeting the cultural needs of each resident. Extended whanau/friends are welcome anytime and to join in the activities programme. The service promotes equal access to services for Maori residents. There is one staff member who identifies as Maori. Staff understood the service's policy on abuse and neglect including what to do should there be any signs. Education on abuse and neglect was confirmed during orientation and annually. There is a Maori advisor available to the service if and when required.

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	All residents at this facility have equal access to services and are not discriminated against or prejudiced because of race, sex, creed, gender and/or religious beliefs. The registered nurses ensure that any cultural needs are identified on admission and are communicated to the healthcare assistants who provide the majority of personal care to residents. Staff reported they received training in cultural awareness. Cultural needs are documented on the resident centred care plans reviewed inclusive of which iwi the resident belongs to. The residents' records reviewed demonstrated consultation with both family/whanau on individual values and beliefs. The family/whanau and residents interviewed reported they are consulted with the assessment and care planning development.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The organisation's philosophy is adhered to and the service encourages and promotes good practice through providing a caring environment. The clinical manager and the registered nurses promote and encourage best practice with staff. Evidence of this was demonstrated in interviews with the registered nurses and healthcare assistants. Additional professional support is sought as required from nurse specialists, wound care specialists, a psycho-geriatrician and the hospice palliative care team. A planned education programme organisation wide for both registered

		nurses and health care assistants is held annually to cover all mandatory training. The clinical manager attends a conference annually arranged by the organisation. Staff reported they receive management support for external education and access to their professional networks to support contemporary good practice The general practitioner interviewed confirmed the service sought prompt and appropriate medical intervention when required 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	Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff interviewed understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code. Staff understood how to access interpreter services when required through the DHB.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. A sample of monthly reports to the board of directors showed adequate information to monitor performance is reported including occupancy, staffing, financial performance, emerging risks and issues. The service is managed by a BCM who holds relevant qualifications and has been in the role for four years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The BCM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through the organisation's annual training for managers and local sector meetings. The service holds contracts with the district health board (DHB) for

		respite care, hospital care (medical and geriatric services) rest home and palliative care and with the Ministry of Health (MoH) for Younger Persons with a Disability (YPD) services. Forty residents were receiving services under the contract (20 hospital residents including two YPD and 20 rest home residents including two respite residents) at the time of audit. New Provider Interview July 2018: The new provider is Heritage Lifecare Limited (HLL), an established New Zealand aged care provider, operating more than 2042 beds in the sector. This proposed acquisition will add a further five facilities across the country. An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017). The transition plan is led by an experienced and well-qualified project team who are specifically focussing on the integration of the current facilities into the Heritage Lifecare Ltd group. This includes provision of infrastructure support such as providing information technology capability including hardware and software. Regional workshops are planned to introduce documentation, and the new HLL systems and processes. This is planned to occur within the first three months. The project team is working with the Chiswick Park team to ensure a smooth transition of each operation. It is expected that the senior team will remain in place at each facility. It is expected that existing staff will transfer to the new provider. The prospective purchaser has notified the relevant District Health Board prior to the provisional audit(s) being undertaken.
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	When the BCM is absent, the clinical manager (CM) carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. New Provider Interview July 2018:

		The prospective provider is not planning any staffing changes. Existing cover arrangements for the day to day operations will remain in place, with access to regional operations managers. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.
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 organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, and clinical incidents including infections and restraints. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting, quality and risk and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and ongoing feedback at meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed dissatisfaction with the food service. The facility has since employed a chef to manage the kitchen with a noted improvement in the food service as confirmed in residents meeting minutes, and during interview. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The BCM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.

		New Provider Interview July 2018: During the transition phase, HLL policies and procedures will be introduced. A new software system will be introduced to incorporate risk management including adverse event reporting, care planning and client management. This is anticipated to be within six months of the purchase. HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure. A key strategy to introduce a national clinical governance group is planned in the next 12 months.
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	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to head office on the intranet. The BCM described essential notification reporting requirements, including for pressure injuries. They advised there has been two notifications of significant events made to the Ministry of Health, since the previous audit. Documentation reviewed confirmed notifications. New Provider Interview July 2018: There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The national quality manager interviewed was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.

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.	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after three-months and then annually. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of four weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has either a current first aid certificate or is an RN with a current CPR certificate. There is 24 hour/seven days a week (24//7) RN coverage in the hospital. New Provider Interview July 2018:

		The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the Guidelines for safe staffing level and indicators. The representative for HLL interviewed was able to confirm understanding of the required skill mix to ensure rest home and hospital care residents' needs are met. The organisation already provides the range of levels of care (Hospital - geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Personal information is entered in all residents' records sighted. Records are maintained in an integrated folder with coloured divisions for each section. There is a contents list at the front of each individual resident's record. All entries were documented clearly and were legible with appropriate signatures and designations as required. The resident register is maintained electronically. Resident records are stored appropriately and securely. Archived records are stored in a manner that they can be retrieved if required. Records are not accessible to the public or unauthorised persons.
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 the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or families are encouraged to visit the facility prior to admission and meet with the clinical manager and/or the facility administrator. They are provided with written information about the service and the admission process. The organisation seeks updates information from NASC or the general practitioner/nurse practitioner for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Records reviewed contained completed demographic detail, assessments and signed admission agreements in

		accordance with contractual requirements. All residents at the facility have been pre-assessed prior to admission as required, whether rest home or hospital level care.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The clinical manager interviewed stated risks are identified prior to planned discharges. Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. A transfer was observed in progress on the day of the audit. The service uses the DHBs `pink envelope` system to facilitate transfer of residents to and from acute services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including the medication records is provided for the ongoing management of the resident. All referrals are documented in the progress records. Familiy reported being kept well informed during the transfer of their relative to the DHB.
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.	FA	The medication management policy is current and identifies all aspects of medicine management. A safe system for medicine management was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Five senior healthcare assistants have been assessed as competent as ‘checkers.’ Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription and entered into the electronic system. All medication sighted were within current use by dates. Clinical pharmacist input is provided and six-monthly audits are completed. The medicine records are reviewed electronically by the GP every three months or as required. All medication records have a photograph of the resident to assist with the identification of the resident. Photographs used for resident identification are dated. Additional hard copy medication records for use of topical ointments or other non-regular medication is

		reviewed three monthly by the GP. The records of temperatures for the medication fridge are within the recommended range. The requirements for pro re nata (PRN) medicines is met. There were no residents self-administering medications at the time of the audit. Appropriate processes are in place to ensure this is managed if required in a safe manner. Any medication errors are reported to the clinical manager and recorded on an incident form. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified. Standing orders are used, are current and comply with guidelines and legislative requirements. There is a copy the standing orders attached to the side of each of the two medication trollies.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued 20 May 2018. Food temperatures, including high risk items, are monitored appropriately and recorded as part of the plan. The qualified chef interviewed has undertaken a safe food handling qualification with kitchen assistants at the main kitchen also completing relevant food handling training. The two main meals lunch and dinner are served in the dining room. Residents have a choice of having breakfast in the dining room or in their own room. Staff assist with placing meals on the tables from the servery provided. Care staff are responsible for assisting residents with their meals and the kitchen hands clear the tables and wash the dishes after the two main meals. The menu used is a four week rotating menu that follows summer and winter patterns and has been reviewed by the organisation’s dietitian within the last two years (February 2018). The menu is displayed daily in two areas of the facility. A dietary/nutritional assessment is undertaken for each resident on admission by the registered nurse and a dietary profile developed. The personal food preferences, any special diets and modified texture

		requirements are made known to the chef. Kitchen hands are guided by the information displaying the dietary needs of residents on a whiteboard in the kitchen to ensure the special needs of the residents are met. Additional food and nutritional snacks are available 24 hours a day. The families and residents interviewed reported they were satisfied with the food and fluid service.
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 no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the service offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family/whanau. There is a clause in the access agreement related to when a resident`s placement can be terminated. An electronic system is used as a data base used for all resident information and this is well maintained by management at the organisation’s head office.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All new residents admitted to this service have an interRAI assessment completed after three weeks of admission by their primary nurse. The assessments include the review of any previous interRAI assessments, such as homecare, and/or needs assessment service coordinators comments. Additional information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, pressure injury, nutritional/dietary screening and depression scale if required, as a means to identify any deficits and to inform care planning. The sample of person centred care plans reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by one of the seven trained interRAI assessors on site. Residents, staff and families interviewed reported appropriate care is provided that meets identified needs.
Standard 1.3.5: Planning	FA	Plans reviewed reflected the support needs of residents, and the

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.		outcomes of the integrated assessment process and other relevant clinical information. Person centred care plans evidence service integration with progress records, activities records, medical and allied health professional`s notations clearly written, informative and relevant. Any change of care required is documented and verbally passed on to relevant staff. The clinical manager and registered nurses interviewed demonstrated understanding of the interRAI process. The person-centred care plans and activities plans identified resident's individual activities, motivational and recreational requirements with documented evidence of how these are managed effectively for the individual resident. Appropriate interventions were documented on each care plan sighted. Residents and families reported participation in the development and ongoing evaluation of care plans. The clinical manager, registered nurses, general practitioner and healthcare assistants reported they receive adequate information to assist with the continuity of care for each individual resident.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident`s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. Care staff interviewed confirmed that care was provided as outlined in documentation. The service has a range of equipment and resources, such as wound dressings and continence products, being readily available suited to the levels of care provided and in accordance with the individual resident's needs.
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	The monthly activities plan (sighted) is developed based on the resident's needs, interests, skill and strengths. A weekly plan is displayed in all service areas and in the individual resident's room. The

age, culture, and the setting of the service.		activities officer assists with the planned activities five days a week with the programme reviewed by a diversional therapist. The coordinator covers all services and evaluates and reviews the individual resident's participation in activities monthly. The sighted programme covers cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities provided. Individual one on one activities are arranged for the two younger persons disabled. The aim is to engage residents' interests and long-term memories. The activities coordinator interviewed reported that this gives the residents a sense of purpose and belonging and meaningful activities reflected normal life interests. The activities coordinator also reported that there is an element of flexibility to change activities based on the resident's response. Photos of events are placed on the magnetic wall on a regular basis. The service provides easy access for using the total mobility service contracted for outings as needed and/or the company van from another facility. Families are encouraged to join in the daily activities programme and special events are planned and family are invited. A church service is held monthly. Communion is available and Christian groups are welcome to visit the facility. Family/whanau and residents report that they enjoy a range and variety of planned activities. Residents are encouraged to maintain links with family/whanau and the community. Special events are celebrated for example birthdays, anniversaries, cultural days and other special events.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress records. If any change is noted, it is reported to the registered nurse or the clinical manager. Formal person centred care plan evaluations, occur every six months in conjunction with the six monthly interRAI reassessment or as residents` needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to

		the plan of care. Examples of short term care plans were consistently reviewed for behaviour management, following falls, skin tears, pressure injuries, and progress was evaluated as clinically indicated and according to the degree of risk noted during the assessment process. The healthcare assistants interviewed demonstrated a good knowledge of short term care plans and reported that these are identified, and information is shared at handover between shifts. Other plans, such as wound management, were evaluated each time the dressing was changed. Residents and families/representatives interviewed provided examples of involvement in evaluation of progress and any resulting changes. There was evidence of multidisciplinary reviews being undertaken in the records reviewed.
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	Residents are supported to access or seek referral to other health and/or disability service providers. Options are provided when required. Although the service has contracted general practitioners, residents may choose to use another medical practitioner. The GP interviewed visits residents' after hours. The GP commented that services responded promptly to referrals sent. If the need for other non-urgent services is indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals sighted in residents` records, included orthopaedic, eye clinic, mental health services for older persons, dietitian and other specialists. Referrals are followed up on a regular basis by the general practitioner. The resident and the family/representative are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to the DHB if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required training. An external company is contracted to

harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this.
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 (expiry date 7 July 2019) is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe, and independence was promoted. External areas are safely maintained and appropriate to the resident groups and setting. Residents and staff confirmed they knew the process they should follow if any repairs or maintenance is required, that any requests are appropriately actioned and that they were happy with the environment. New Provider Interview July 2018: HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each facility. There are presently no plans for any environmental changes in the facilities.
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 bathroom and toilet facilities throughout the facility. This includes two rooms with full ensuites. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.

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	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents 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	Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site in a dedicated laundry, and by family members if requested. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. There is a small designated cleaning team who have received appropriate training. These staff have completed the appropriate training including for chemical handling. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and the external chemical contractor.
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 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 the 15 March 2004. A trial evacuation takes

		place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 13 March 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the full number of residents. Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and an external monitoring system is in place.
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 are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto the outside garden. Heating is provided by electric panel heating in residents' rooms and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
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 infection control programme and manual are reviewed annually (last reviewed 20 April 2018) and this was signed off officially in June 2018.The service provides a managed environment that minimises the risk of infections to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the clinical manager and the organisation`s support management team.

		The infection control nurse (ICN) is an experienced registered nurse, whose role and responsibilities are defined in a position description. The infection control nurse has been in this role for four months. Infection control matters, including surveillance results, are reported monthly to the clinical manager, and tabled at the quality/staff meetings. The quality committee includes representatives from all areas of service delivery. Signage at the reception to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.
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	The ICN is supported by the clinical manager. Well established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The ICN has access to the residents' records and to diagnostic results to ensure timely treatment and resolution of any infections. The ICN confirmed the availability of resources to support the programme and any outbreak of an infection. There have been no infection outbreaks at this facility since the previous audit. An outbreak management plan is developed and available for any event and 'lockdown' of the facility would be instigated and wings can be closed off respectively. The clinical manager, registered nurses and healthcare assistants interviewed demonstrated good infection prevention and control techniques and awareness of standard precautions such as hand washing and the use of personal protective equipment.
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	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard. Policies were last reviewed April 2018 and included appropriate referencing. There are clear definitions of infections and an identification of infections form

implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		available. There is a notifiable diseases list in the manual sighted. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitises, good hand washing technique and use of personal protective equipment, such as hats, disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed demonstrated safe and appropriate infection prevention and control practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control nurse. Content of training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Education for residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their own room if they are unwell, increasing fluids and an 'ice block round' observed each day in the afternoon.
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, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented on the infection clinical record. The infection prevention and control nurse reviews all reported infections and maintains a log for each type of infection. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and any required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers observed. Graphs are produced that

		identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager who reports to the organisation`s head office. Data is benchmarked with other facilities. Benchmarking with other services within the organisation has provided reassurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures, practice and the responsibilities of the role. On the day of audit, three residents were using restraints and five residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. New Provider Interview July 2018: HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for use of enablers. These policies are implemented across the group and a small number of restraint devices are approved for use following assessment. The prospective provider is experienced in the requirements of the standard, as it pertains to aged residential care.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on	FA	The restraint approval group, made up of the GP, CM, BCM and key health care assistants (HCA), are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews

restraint use and this process is made known to service providers and others.		with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The RN/restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example the use of sensor mats and low beds. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record. Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of

		restraint is to be minimised and how to maintain safety when in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the RN/restraint coordinator confirmed that the use of restraint has been reduced at Cheswick and across Oceania facilities over the past five years.

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, 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.