# Policy Directive

Ministry of Health, NSW
73 Miller Street North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Telephone (02) 9391 9000 Fax (02) 9391 9101
http://www.health.nsw.gov.au/policies/

## Nursing Home Type Patients and the National Acute Care Certificate

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| **Functional Sub group** | Corporate Administration - Fees |
| **Summary** | This Policy Directive advises requirements in relation to administratiion of the Nursing Home Type Patients contribution and the National Acute Care Certificate. |
| **Author Branch** | Finance |
| **Branch contact** | Finance 02 9391 9158 |
| **Applies to** | Local Health Districts, Board Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Public Hospitals, NSW Health Pathology |
| **Audience** | Administration, Fees / Revenue Officers, PLO's, Medical Practitioners |
| **Distributed to** | Public Health System, Ministry of Health |
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| **Policy Manual** | Not applicable |
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| **Status** | Active |

**Director-General**

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

POLICY STATEMENT

# NURSING HOME TYPE PATIENTS AND THE NATIONAL ACUTE CARE CERTIFICATE

## PURPOSE

This Policy Directive advises requirements in relation to administration of the Nursing Home Type Patient (NHTP) contribution and the National Acute Care Certificate (NACC).

## MANDATORY REQUIREMENTS

All public hospitals are required to comply with the attached procedures.

Patients who remain in a public hospital bed after 35 days must have their care type assessed by a medical practitioner and the need for continuing hospital level care documented in the patient's medical record prior to day 35. In addition for Private and DVA patients a NACC must be issued by a medical practitioner to certify the need for continuous hospital level care beyond 35 days.

A key change advised in this policy is that NACC's are no longer required for Public patients.

Patients no longer requiring hospital level care beyond 35 days must have their care type changed to Maintenance Care and financial class to NHTP.

Fees are to be raised for NHTP's consistent with the attached procedures.

## IMPLEMENTATION

Local Health District / Speciality Health Network Chief Executives are to ensure that the requirements of this Policy Directive are communicated to all appropriate staff.

Directors of Finance, Revenue Managers, Hospital Admission Staff, Patient Liaison Officers and Patient Billing Staff are responsible for the operational compliance of this Policy Directive and Procedures.

Staff can access the State-wide Revenue Toolkit at http://staterevenue.wsahs.nsw.gov.au for further information on policy application and implementation.

## REVISION HISTORY

| Version | Approved by | Amendment notes |
|---|---|---|
| April 2016 (PD2016_011) | Secretary, NSW Health | New Policy Directive – updates and replaces policy previously advised in the Fees Procedures Manual. |

## ATTACHMENTS

1. Nursing Home Type Patients and the National Acute Care Certificate - Procedures.

# Nursing Home Type Patients and the National Acute Care Certificate

NSW GOVERNMENT Health

PROCEDURES

**Issue date:** April-2016

PD2016_011

# CONTENTS

# 1 BACKGROUND

## 1.1 About this document

This Policy Directive advises requirements in relation to administration of the Nursing Home Type Patient (NHTP) contribution and the National Acute Care Certificate (NACC).

This policy does not apply to Motor Accident Third Party, Workers Compensation, Other Compensable or Ineligible patients.

Patients who remain in a public hospital bed after 35 days continuous care at one or more hospitals and no longer require hospital level care, i.e. the patient only requires nursing care and accommodation as an end in itself, are charged a daily NHTP contribution as determined by the Commonwealth Department of Health.

Inpatient accommodation rates payable by Private Health Insurers (PHI) for Private patients and Department of Veterans Affairs (DVA) for DVA patients are reduced once the patient is deemed to be subject to the NHTP contribution. For this reason, if the Private or DVA patient remains in need of hospital level care following 35 days continuous care, a NACC certificate is required by PHI and DVA to provide certification and justification for continuation of the higher inpatient accommodation rate.

## 1.2 Key definitions

In this policy directive:-

- **Hospital Level Care,** refer to section 2.1 of this document.
- **Continuous care,** refer to section 2.2 of this document.
- **Nursing Home Type Patient (NHTP)** refers to a patient who has been in one or more hospitals (public or private) for a period of more than 35 days continuous care, and who is **not** deemed to be receiving hospital level care (i.e. the patient only requires nursing care and accommodation as an end in itself).
- **National Acute Care Certificate (NACC)** refers to a document required by private health insurers (PHI) and the Department of Veterans Affairs (DVA) to certify a patient's need for long term hospital level care.
- **Maintenance Care,** refer to Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care (PD2014_010).

## 1.3 Legal and legislative framework

These procedures are in line with requirements from the *National Health Reform Agreement 2011, Private Health Insurance (Benefit Requirements) Rules 2011* and the *Pension Based Fees - Charging Arrangements and Scale of Fees.*

# 2 NURSING HOME TYPE PATIENT (NHTP)

NHTP refers to a patient who has been in one or more hospitals (public or private) for a continuous period of more than 35 days, with a maximum break of no greater than seven days, who is not deemed to be receiving ***hospital level care*** (i.e. the patient only requires accommodation and nursing care, as an end in itself).

A patient no longer requiring hospital level care beyond 35 days must have their care type assessed and evidenced by documentation in the patient medical record prior to day 35. Hospital administration staff must be notified of this change. The patient's care type must be changed to Maintenance Care and the patient must be fully informed of all changes and charges seven days prior to the financial class being changed to Nursing Home Type (NHTP).

Should a patient's care type be changed to Maintenance Care prior to day 35 the patient's financial classification does not change to NHTP until day 36.

If a patient classified as NHTP subsequently requires ***hospital level care*** this must be evidenced by documentation in the patient medical record to support a change in care type and financial classification.

In the case of Private and DVA patients a NACC must be issued. Following the period of hospital level care the patient must have a care type change back to Maintenance Care and a financial classification change back to NHTP.

## 2.1 Guidelines for assessing Hospital Level Care

**Hospital Level Care** includes active, inpatient treatment which is clinically necessary for the intensive optimal management of acute conditions, effective management of exacerbations of symptoms in a chronic condition or where outpatient treatment has been ineffective in a chronic condition, or for life support.

The need for hospital level care refers to those patients whose medical condition requires medical and nursing care which is intensive, active and requires regular monitoring in an inpatient setting. In the context of this policy, hospital level care does not refer to treatment being provided to those patients whose medical condition has become stabilised, and the treatment and management being provided is of a routine and/or supportive nature.

Rehabilitation is considered part of hospital level care if it is being provided by a hospital with rehabilitation facilities and appropriately qualified personnel in order to improve a patient's functional capacity to a level that will enable the patient to be returned to his or her environment. It does not include ongoing supportive therapy.

Hospital level care includes treatment during the post-operative recovery period, including the treatment of any post-operative complications and/or complications arising from any diagnostic or therapeutic procedure.

Some terminally ill patients in hospitals may be considered as needing hospital level care. This will depend on the level of active medical intervention.

Patients remaining in hospital while awaiting nursing home placement should not be considered as requiring hospital level care.

In evaluating the need for hospital level care the following factors should be considered:

- Does the patient require care which should be provided in an acute hospital bed?
- Does the condition of the patient require treatment and investigation procedures which are unavailable in a nursing home?
- Is the treatment being given likely to further improve the patient in the short term with the intention of returning the patient to his or her previous environment?
- Is the degree of improvement consistent with the time interval between initiation and completion of treatment?
- The relationship between the degree of improvement in the patient's condition and the nature of the treatment provided.

## 2.2 How to calculate continuous care

In the event of readmission to a hospital within seven days, or transfer between hospitals, the previous related inpatient periods will be regarded as contributing towards the period of 35 days continuous care. The date of discharge is not to be counted as one of the seven days. The seven days commences from the day after discharge or on leave.

The periods of leave are not counted towards the 35 day qualifying period; therefore, a patient who has been in hospital for 20 days and then leaves the hospital for 3 days will start at day 21 when returning to hospital. Similarly, where a patient is discharged and a period of more than seven days elapses before readmission, the previous stay in hospital will not be counted.

If a patient is transferred from one hospital to another, all relevant documentation of the patient's prior length of stay must be provided to the admissions department of the hospital to which the patient is transferred. This is to determine the total length of stay.

In cases where the patient's length of stay in hospital has been broken by periods of less than seven days, this will require all relevant admission and separation dates from the previous hospital be forwarded to the new hospital. Private hospitals will be asked to supply this information for all transfers to public hospitals.

The acute care calculator is available on the NSW Health Revenue Toolkit Tools & Resources intranet page.

## 2.3 Patient Contribution Fees

NHTPs are required to pay a patient contribution (fee) as set by the Commonwealth Department of Health. The patient contribution fee is uninsurable and charged as a daily rate to the patient.

The rates are reviewed in March and September each year in line with Australian pension / benefit adjustments.

Pension patients may be eligible for various assistance payments such as single pension and rent assistance depending on their individual circumstance. Patients should be referred to the Department of Human Services for current details and application information.

NHTP rates can be found in the current policy directive titled *Pension Based Fees – Charging Arrangements and Scale of Fees*.

### 2.4 Patient Communication

Patients must be informed verbally and in writing at least seven days prior to their financial classification change to NHTP and commencement of charging the daily patient contribution. A sample letter can be found on the NSW Health Intranet Revenue Toolkit tools and resources page (Attachment 2).

Once patients have been given notification and all information related to the associated fee they should be asked to sign a Nursing Home Type Patient – Accommodation Contribution Agreement (Attachment 3).

## 3 PUBLIC PATIENT

A NACC is not required for public patients requiring the continuance of hospital level care beyond 35 days. The patients care type must be assessed by a medical practitioner and the need for continuing hospital level care documented in the patient medical record prior to day 35.

Public patients no longer requiring hospital level care beyond 35 days must also have their care type evidenced by documentation in the patient medical record and be brought to the attention of administration staff as soon as possible. The patient's care type must be changed to Maintenance Care as at the day of assessment, and the financial class changed to Public-Nursing Home Type from day 36.

For Public NHTPs a patient contribution (fee) applies as per section 2.3 of this document.

## 4 PRIVATE AND DEPARTMENT OF VETERANS AFFAIRS (DVA) PATIENTS AND THE NATIONAL ACUTE CARE CERTIFICATE

All Private and DVA patients requiring hospital level care beyond 35 days must have their care type assessed and the need for continuing hospital level care documented in the medical record prior to day 35.

In addition, a NACC must be issued by a medical practitioner to certify to the PHI and DVA the need for continuous hospital level care beyond 35 days and every 30 days thereafter as long as the Private or DVA patient requires hospital level care.

For Private patients the original copy of each completed NACC should be forwarded with accounts to the Private Health Insurer (PHI) as soon as possible to ensure continuation of payment at the acute care accommodation rate. A copy of the NACC is to be kept with the patient records.

The PHI needs to be informed of any changes which may affect the processing or consideration of a NACC (e.g. revised prognosis or death of a patient). If the doctor forms the opinion that the patient no longer requires hospital level care, the PHI needs to be informed that the NACC has been revoked.

For DVA patients the original NACC must remain with the patient record and is to be supplied to DVA upon request.

Private and DVA patients no longer requiring hospital level care beyond 35 days must have their care type evidenced by documentation in the patient health record and be brought to the attention of administration staff as soon as possible. The patient's care type must be changed to Maintenance Care and financial class to Private-Nursing Home Type or DVA-Nursing Home Type.

For Private and DVA NHTPs a patient contribution applies as per section 2.3 of this document. For Private patients an additional charge (difference between "Patient Contribution" and "Patient Contribution plus Fund Benefit" rates) is recoverable from the patient's health fund.

If a patient classified as Private or DVA NHTP subsequently requires hospital level care, a NACC must be issued to support a change in care type and financial classification. Following the period of hospital level care, unless a NACC is issued the patient must have a care type change back to Maintenance Care and a financial classification change back to NHTP.

A new HC.21 form should be issued each time a private patient is reclassified to or from the NHTP patient category.

### 4.1 Guidelines for issuing a National Acute Care Certificate

The NACC must only be completed by the treating registered medical practitioner who must provide a prognosis and his/her opinion of the probable duration of further acute care.

Allied health and nursing professionals involved in the care of the patient may assist with section 3 of the NACC but cannot certify the certificate.

The NACC may be completed up to 14 days in advance of the commencement of the period covered in the NACC and may be completed retrospectively in exceptional cases.

### 4.2 Absence of Acute Care Certificates - Charges to Patients

When a Private or DVA patient is considered to be legitimately in need of hospital level care but the doctor has not completed a NACC, the patient should not be charged the patient contribution until it is determined by the Director of Medical Services, or similar delegation, that the classification of "NHTP" is warranted.

Every effort should be made to ensure that NACCs are completed.

## 5 PAYMENT METHODS AND DEBT RECOVERY

### 5.1 Payment Method

All patients have the right to decide the method of payment of the NHTP contribution. Direct debit is the preferred payment option (Attachment 4).

Only in exceptional circumstances will the Commonwealth Department of Human Services overrule a patient's choice of payment method. When a pensioner patient refuses to pay the required contribution, there is a provision for the hospital to apply for guardianship if it is shown to be in the best interests of the patient.

### 5.2 Debt Recovery

Where for any reason payment is not made, Local Health District debt recovery procedures for the recovery of outstanding hospital accounts should be followed, in accordance with *NSW Treasurer's Direction 93/4 Recovery of debts owed to the State.*

If the patient is not in receipt of a pension and genuinely considers themselves disadvantaged by the daily contribution fee, an application form for financial hardship can be found on the NSW Health Intranet Revenue Toolkit forms page.

## 6 LIST OF ATTACHMENTS

1. National Acute Care Certificate (NACC)
2. Sample notification letter for Nursing Home Type Patients (NHTP)
3. Sample Nursing Home Type Patient – Accommodation Contribution Agreement
4. Sample Nursing Home Type Patient – Direct Debit Request Service Agreement
5. Implementation Checklist

## 7 REFERENCES AND RELATED POLICIES

National Health Reform Agreement 2011

Private Health Insurance (Benefit Requirements) Rules 2011

Pension Based Fees – Charging Arrangements and Scale of Fees

Fees Procedure Manual for Public Health Organisations

Circular No. 108/1986 Nursing Home Type Patient Arrangement in Recognised hospitals – Retrospectivity of Section 3B Certificates.

Multipurpose Services - Policy and Operational Guidelines (PD2010_049)

# Attachment 1: National Acute Care Certificate

## Section 1 – Particulars of Patient and Hospital (to be completed by Hospital, Doctor or Patient)

Patient's Surname_____Given Names_____

Address_____Postcode_____

Date of Birth ____/___/_____Gender M / Full Name of Hospital _____

Health Fund Name _____Membership Number _____

Date of original admission____/___/____being the date from which the patient has been continuously an overnight patient in this or any other hospital(s), without a break of more than seven days.

Certificate _____ of this continuous admission (insert 1, 2, 3 etc. to show sequence)

Has the patient been discharged? [ ] Yes [ ] No If Yes, date of discharge _____/_____/_____

Has the patient been transferred [ ] to, or [ ] from, another hospital? [ ] Yes [ ] No

If Yes, name of hospital _____

## Section 2 – Patient Authorisation (to be completed by –Patient, Parent, Guardian or Power of Attorney)

I, _____ authorise the _____
Hospital/and Health Service, to complete this certificate and release to my health fund or funding agency health information relevant to the conditions that required acute care during the certified period including confidential and personal identifying and non-identifying information to confirm whether acute treatment has been provided and to verify the claims necessary to process the payment of accounts for treatment or diagnostic tests as described in Section 3 below.

Signature _____ Relationship _____ Date _ ____/_____/_____

## Section 3 – Certification of Patient's Medical Condition (to be completed by and/or certified by ***treating doctor***)

I,_____ Telephone No._____

of_____certify that the above patient:

[ ] no longer requires acute care; OR

[ ] required/will require acute care for at least the period commencing _____/_____/_____
and ending _____/_____/_____(no later than 30 days from commencement).

Treatment type during the certified period (tick the appropriate box):

[ ] Psychiatric [ ] Acute Medical [ ] Acute Surgical [ ] Palliative Care [ ] Hospital in the Home

[ ] Rehabilitation [ ] Other (specify) _____

Has the patient had an ACAS (ACAT) assessment during the certified period [ ] Yes [ ] No

Please state the condition(s) that required acute care during the certified period:

_____

_____

Please state the co-morbidities/complications that were also treated during the certified period:

## Section 3 – Certification of Patient's Medical Condition (cont.)

Please document the services or interventions that describe the acute care provided to the patient in the certified period.

| Discipline | Services or interventions (related to acute care) | Frequency (e.g. daily/3xweek etc.) | Date ended |
|---|---|---|---|
| Surgeon/ Physician | | | |
| Nursing | | | |
| Allied Health | | | |
| Other | | | |

If the patient has not been discharged, please state the prognosis and opinion of probable duration of the continuing need for acute care (to be completed by the treating doctor):

_____

_____

_____

_____

I confirm the information documented in Section 3 of this acute care certificate is accurate.

Signature of ***treating doctor*** _____

Name ***of treating doctor*** _____ (please print)

Date: _____/____/___

## Attachment 2: Sample notification letter for Nursing Home Type Patients

AUID: **«PatientID»**
«PatientTitle» «PatientForename» «PatientSurname»
«PatientAddressLine1»
«PatientSuburb» «PatientState» «PatientPostCode»

Dear «PatientTitle» «PatientSurname»

**RE: Accommodation Contribution**

Your attending clinician has determined that you will no longer require hospital level care from **(*insert: the end date in the acute care certificate*)**, and as a result you will be reclassified as a Nursing Home Type patient. This change in classification will not affect your entitlements to hospital services, the quality of care received, or the professional relationship between you and your attending clinician.

For the remainder of your stay, as a Nursing Home Type patient, you will be charged an accommodation contribution of **$XX.XX** per day**.** This accommodation contribution is determined by NSW Health and the Commonwealth Department of Health.

We are able to offer *direct debit* facilities from your nominated bank account as a convenient way to pay your contribution. Please find the direct debit form attached. If you have appointed someone to handle your finances, please advise our hospital administration staff.

We recommend you contact Centrelink or the Department of Veterans Affairs to advise them of changes in your circumstances and to determine your eligibility for additional benefits, such as rent assistance.

The accommodation contribution still applies if you hold private health insurance and have elected to be treated as a private patient. Note that your private health fund will also be charged a daily Nursing Home Type Patient fee.

Should you have any concerns about the above charges, or require any further information or assistance, please contact our hospital administration staff. Please complete and return the attached Accommodation Contribution Agreement to confirm that you have read and understood this advice.

Yours sincerely,

**Health Service Manager**
**«FacilityName»**

## Attachment 3: Sample Nursing Home Type Patient – Accommodation Contribution Agreement

**Nursing Home Type Patient - Accommodation Contribution Agreement**

**Patient**

I, **«PatientForename» «PatientSurname»,** of **«PatientAddressLine1» «PatientAddressLine2» «PatientSuburb» «PatientState» «PatientPostCode»**, confirm that I have received and understood the advice given to me in relation to Nursing Home Type Patient reclassification and associated fees (Accommodation Contribution). I understand that I am responsible for the Accommodation Contribution. The reasons for the contribution, as well as direct debit options, have been explained to me.

Signature _____ Date_____

**Or authorised representative (on behalf of patient)**

I, _____

of _____

have received and understood the information given to me in relation to Nursing Home Type Patient reclassification and fees for **«PatientForename» «PatientSurname», of «PatientAddressLine1» «PatientAddressLine2» «PatientSuburb» «PatientState» «PatientPostCode»,**

I am the patient's authorised representative in relation to finance matters. My appointment as representative has been discussed with the Health Service Manager and appropriate documentation to evidence my appointment as authorised representative has been provided.

Signature _____ Date _____

Relationship to patient _____

## Attachment 4: Sample Direct Debit Request Service Agreement

### [YOUR] Local Health District
### Direct Debit Request Service Agreement

For your convenience, [YOUR] Local Health District is pleased to offer the option to pay health service fees by *direct debit* against your nominated bank account.

There will be no additional cost incurred by entering into this agreement. The Local Health District will bear the expense of any financial institution transaction fees associated with this process.

**Direct Debit Process**

By completing the *Direct Debit Request Form*, you authorise the Health District to debit your nominated bank account and transfer funds to the Health District bank account.

Funds will be transferred on a fortnightly basis as stipulated on the *direct debit request* form. The payment amount shall be the daily patient contribution fee calculated at the fortnightly amount.

At the end of each month a *Statement of Account* detailing the charges raised for that month and the fees transferred during that month will be available on request from the Central Revenue Unit.

**Alteration of Direct Debit Arrangements**

Where a variation (deferment, alteration or cessation) to the agreed arrangements is to be made by either party, 14 days written notice is to be provided detailing the proposed change before the variation may be effected. Such written advice will detail the reason for the variation, the new payment amount and the effective date.

Customers seeking to alter a direct debit arrangement should forward their written advice to:

**[YOUR] Local Health District**
**Finance Division – Central Revenue Unit**
**[PO Box XXXX]**
**[TOWN NSW POSTCODE]**

**Dispute Resolution Process**

Should there be any reason to dispute or seek clarification of any debit item made against your account all such requests should be directed to the [YOUR] Local Health District, Central Revenue Unit in the first instance.

Please contact the Central Revenue Unit during business hours on **[XX XXXX XXXX]**

**Your Responsibilities**

It is your responsibility to ensure that sufficient funds are available in your nominated account on the payment day as per the agreement. Please note that where insufficient funds lead to a direct debit item being returned, a charge may be applied to your account by the financial institution.

*Direct debit* is not available on all account types. If uncertain, please confirm your account details with your financial institution before completing a *Direct Debit Request*.

**Where Payment Date falls on a weekend or public holiday**

Where an agreed payment date falls on a day which is not a business day, the direct debit will occur on the next available business day.

**Debit Items Returned Unpaid**

[YOUR] Local Health District will advise you, in writing, of any rejections on the next business day following the debit item rejection.

**Privacy Policy Statement**

All bank account and personal details provided by you for the purpose of entering into *a Direct Debit Request* will be held on a strictly confidential basis.

The information provided will be used for the sole purpose of initiating a direct debit against your nominated bank account in accordance with the terms of the agreement.

[YOUR] Local Health District undertakes not to disclose or release to any person or organisation the details provided in the *Direct Debit Request* without your written consent.

Where a financial institution seeks information or clarification of account details in relation to a claim made on it relating to an alleged incorrect or wrongful debit item, [YOUR] Local Health District will provide such details as necessary to correct or complete the direct debit transaction.

**[YOUR] Local Health District**

Please contact the Central Revenue Unit for all information relating *to Direct Debit Requests.*

Mailing address: **[YOUR] Local Health District**
**Finance Division – Central Revenue Unit**
**[PO Box XXXX**
**[TOWN NSW POSTCODE]**

**Tel: [XX XXXX XXXX]**
**Fax: [XX XXXX XXXX]**

## Direct Debit Request

**Residents' Authority**

(Name of Resident) «PatientForename» «PatientSurname»

(Patient AUID) «PatientID»

I, _____

(Name of Debit User)

authorise **[YOUR] Local Health District**

APCA User ID No **[XXXXXX]**

to arrange for funds to be debited from my/our account at the financial institution identified below and as prescribed below through the Bulk Electronic Clearing System (BECS).

This authorisation is to remain in force in accordance with the terms described in the Service Agreement

**Resident / Power of attorney signature**

**Details of the Account to be Debited**

(All details must be supplied)

**Name of the Financial Institution**

**Account Name**

**BSB Number** | **Account number** | **Branch Name**

**Payment Details**

The payment is for **Accommodation Contribution**

identified by

**Payment Options**

I/We request that you debit my/our account in accordance with our Agreement and subject to the following conditions:-

Maximum amount to be debited **$**

Frequency of Debit **Fortnightly**

First payment date / /

Final payment date / /

**NOTE:** Customers are asked to consult with the Finance Division - Central Revenue Unit to ascertain/confirm the amount to be debited and the commencement date for the purposes of this request.

**Financial Institution Consent**

I/We also authorise the following:

1. The debit user to verify the details of the abovementioned account with my/our Financial Institution.
2. The financial Institution to release information allowing the Debit User to verify the above mentioned account details.

Signature _____ Date / /

Signature _____ Date / /

## Attachment 5: Implementation checklist

| **LHD/Facility:** | | | |
|---|---|---|---|
| **Assessed by:** | | **Date of Assessment:** | |
| **IMPLEMENTATION REQUIREMENTS** | **Not commenced** | **Partial compliance** | **Full compliance** |
| 1. | ❑ | ❑ | ❑ |
| | Notes: | | |
| 2. | ❑ | ❑ | ❑ |
| | Notes: | | |
| 3. | ❑ | ❑ | ❑ |
| | Notes: | | |
| 4. | ❑ | ❑ | ❑ |
| | Notes: | | |
| 5. | ❑ | ❑ | ❑ |
| | Notes: | | |
| 6. | ❑ | ❑ | ❑ |
| | Notes: | | |