Heritage Lifecare Limited - Edith Cavell Home and Hospital

Introduction

This report records the results of a Surveillance 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:	Edith Cavell Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 August 2018 End date: 21 August 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 55

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Edith Cavell Lifecare provides rest home and hospital level care for up to sixty-three residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

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

Improvements have been made to care planning, addressing the area requiring improvement at the previous audit. There were no areas requiring improvement from this audit.

Consumer rights

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

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the facility and 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 include 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 were 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.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

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 and designated general practitioners. Shift handovers, communication sheets and an electronic resident documentation system guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families/whanau interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme, overseen by an activities coordinator, provides residents with a variety of individual and group activities and maintains their links with the local community. A facility van with wheel chair access is available for outings.

Medicines are managed according to policies and procedures based on current good practice and policies are consistently implemented using an electronic system. Medications are administered by registered nurses with care staff as 'second checkers', all of whom have been assessed as competent to do so.

Food service delivery is supported by staff with food safety qualifications. The kitchen was clean, well-organised and meets food safety standards. Residents verified satisfaction with the meals provided. The food service meets the nutritional needs of the residents with special needs catered for.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no restraints were in use at the time of audit.

Infection prevention and control

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

Aged care infection surveillance is undertaken with data analysed, trended and results reported through all levels of the organisation. Follow up action is taken as and when required.

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	17	0	0	0	0	0
Criteria	0	42	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 1.1.13: 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 facility manager (FM) 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 (the Health and Disability Commissioner's office) and closed by the Commissioner's office
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	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 demonstrated in residents' records and incident forms reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.

provide an environment conducive to effective communication.		Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Heritage Lifecare Limited (HLL) - Edith Cavell Home and Hospital's strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the facility and 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 and support office showed adequate information to monitor performance is reported including occupancy, staffing, financial performance, issues, complaints, incidents and all adverse events. The service is managed by a facility manager (FM) who holds relevant qualifications and has been in the role for two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through the organisation's managers' forum meetings, sector seminars, conferences and professional development. The service holds contracts with the district health board (DHB) for respite, rest home and hospital, and the Ministry of Health (MoH) for younger persons with a disability (YPD). Nineteen residents were receiving services under the rest home contract, thirty-six under hospital care, including one YPD at the time of audit. Three residents were in Occupational Rights Agreement apartments. Apartments are within the facility's hospital environment and included in hospital staffing numbers.
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	HLL- Edith Cavell Home and Hospital 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, clinical incidents including infections and adverse events. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management, staff and quality team meetings. Staff reported their involvement in quality and risk management activities through audit activities and attendance 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 themes related to call bell answer times and puree food temperatures. The service could demonstrate actions taken to show improvement in both areas. 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 were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The FM 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.
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 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 the HHL support office via an electronic reporting system. The FM described essential notification reporting requirements, including for pressure injuries. They advised there have been two notifications of significant events made to the Ministry of Health since the previous audit. One relating to a resident who left the premises at night and another resident who was away with a concern for the resident's safety. Both were managed in a timely manner and resolved safely for the resident.
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 show documentation of completed orientation and a performance review after a three-month period and annually thereafter. 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. The service manages those residents under an ORA and residential care agreement within appropriately trained staff.
Standard 1.2.8: Service	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe

Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		service delivery, 24 hours a day, seven days a week (24/7). This includes residential care residents under an ORA contract. 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 a current first aid certificate and there is 24/7 RN coverage in the hospital.
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 in line with the Medicines Care Guide for Residential Aged Care. A safe system is in place for medicine management using the 'Medimap' electronic system and a blister pack system, as observed on the day of audit. The staff observed were wearing coloured upper body aprons that identified they were giving out medication and not to be disturbed. Staff demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy every four weeks. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly and on request. Medicine reconciliation is occurring, and the designated pharmacy accesses the Medimap system. The pharmacy reviews medications no longer in use weekly and removes them from the facility. Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. Standing orders are no longer required with the current Medimap system, the general practitioner can access the system from the surgery and prescribe immediately the required medication. There was no one self-administering medications on the audit day, however processes and documentation are in place to enable safe administration if this was to occur. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly general practitioner review was consistently recorded on the medicine chart. The general practitioner interviewed confirmed that staff respond promptly to changes in medication and communicate promptly any concerns through the system the general practitioner practice has set up whereby texts and phone calls are responded to promptly.

		Medication errors are reported to the clinical service manager who is a registered nurse and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, reporting to a higher level in the organisation and reporting back to staff. Compliance with this process was verified.
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	The food service is provided on site by an experienced kitchen manager who has worked for the facility for many years and the kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian (June 2018). Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. The facility food control plan was recently audited by the Christchurch City Council. The corrective action was completed and signed off and Edith Cavell Home and Hospital food control plan verified as being successfully implemented and continuing to produce safe and suitable food. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and a white board in the kitchen has individual requirements for residents highlighted to ensure their specific requirements are accommodated in every meal plan. Residents have access to food and fluids to meet their nutritional needs at all times and staff were observed to be regularly offering food and fluids. Special equipment, to meet resident's nutritional needs, is available and observed in use with staff assisting those residents that required help and residents were given sufficient time to eat their meal. Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews, satisfaction surveys, residents' bimonthly meeting minutes and the recently introduced monthly family meetings.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The facility is coordinated in a manner that promotes continuity in service delivery promoting a comprehensive assessment from a multidisciplinary team perspective with involvement of the resident and their family/whanau. The general practitioner, clinical service manager, registered nurses, care staff, activities coordinator and residents, family/whanau interviewed confirmed this was occurring. Information is documented using validated comprehensive multidisciplinary assessment tools, such as advance care directives, mini nutritional assessment, swallowing difficulties assessment, dietary, mobility and transfers, personal hygiene, toileting, oral care, skin integrity, pressure injury risk, falls risk, continence

		assessment, activity assessment, Cornell depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents' files reviewed during the audit had a current interRAI assessment completed by six trained assessors on site. The clinical services manager provides input and oversight for interRAI assessments and lifestyle care plans and reviews are planned six monthly or more frequently as required. Residents' six monthly interRAI assessments were completed in all files reviewed which then informed the care plan review and the interventions triggered in the interRAI assessment were included in all the care plans reviewed addressing the previous shortfall.
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 general practitioner verified that medical input is sought in a timely manner from the clinical service manager and registered nurses, that medical orders are promptly implemented, and that staff ensure that the general practitioner, family/whanau are consulted when a resident's condition changes. The general practitioner reported that care was of a high standard at both rest home and hospital levels of care. Family/whanau interviewed confirmed that they are informed, and their input is included. The clinical service manager, registered nurses and care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' assessed needs. Observed in use were walking frames, pressure injury prevention mattresses, 'roho' cushions, sensor mats, non-slip mats, hoists, shower chairs and raised toilet seats.
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 activities programme is provided by a full time activities coordinator currently completing the diversional therapy training through Careerforce. The activities coordinator has previously completed postgraduate study in arts therapy which has influenced the activity programme in a positive way providing a diverse itinerary to meet the individual needs of residents. The programme fits with the philosophy of the home and hospital whereby residents have the right to flourish and have optimum quality of life incorporating gender, ethnic, cultural, physical, emotional and spiritual needs. This is reflected on the activities schedule which was observed on the wall in residents' rooms.

age, culture, and the setting of the service.		A social assessment and history are undertaken on admission to ascertain resident's individual needs, personal strategies, choices, interests' abilities and social requirements. Family members/whanau are encouraged to participate in the assessment process as confirmed by residents and family/whanau interviewed. The resident's activity needs are revaluated as their needs change, monthly, and as part of the formal six monthly care plan review as evidenced in care plans reviewed. The planned monthly activities programme sighted matches the skills, likes, dislikes, interests, personal strategies and preferences for outings as identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities, individual, group activities with regular events offered. There is a facility van which also accommodates wheelchairs which takes residents out on the planned group visits and one on one outings. Along with the bi monthly residents meeting the facility has implemented a six monthly family meeting where all aspects of care can be discussed including activities. Resident and family satisfaction surveys demonstrated satisfaction with the programme. Residents, family /whanau interviewed confirmed they find the programme is designed to meet their individual needs. Family /whanau are also invited to attend.
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 notes. If any change is noted, it is reported to the RN or CSM and an alert will also be placed on the message board Ecase system to highlight any changes and to ensure all staff are aware. Formal care plan evaluations occur every six months or as residents' needs change. Six-monthly interRAI reassessments are occurring, or more frequently as residents' needs change which then informs changes to the residents' requirements in the care plans. Examples of short term care plans were consistently reviewed for skin tears, falls, infections, any changes in the resident's normal status, and progress was evaluated as clinically indicated at least weekly and according to the degree of risk noted during the assessment process. If ongoing, the short term care plan was transferred into the long term care plan section. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes were discussed with the resident and family/whanau members.
Standard 1.4.2: Facility Specifications Consumers are provided	FA	A current building warrant of fitness (expiry date 01 Dec 2018) is publicly displayed.

with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
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 scabies. When an infection is identified, a record of this is documented in the infection reporting form, individual infection register, in the resident's clinical record, and as an alert in the message board on the resident electronic management system. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Graphs are produced that identify trends for the current year and comparisons against previous years, and this is reported to the clinical services manager, facility manager, quality team and Heritage Lifecare Ltd. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff. There have been no recent outbreaks reported.
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 and practice and her/his role and responsibilities. On the day of audit, no residents were using restraints and no residents were using enablers. There have been no restraints used in the facility for at least two 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.