

Kaylex Care Limited - Eastcare Residential Home

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:	Kaylex Care Limited
Premises audited:	Eastcare Residential Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 10 September 2020 End date: 10 September 2020
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:	42

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
Yellow	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
Red	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

Eastcare Residential Home is one of two facilities owned by Kaylex Care Limited. Eastcare Residential Home provides rest home level care and secure dementia care for up to 48 residents.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, a review of residents' and staff records, observations and interviews with residents, staff, the facility manager and the general practitioner. Residents that were able to be interviewed were pleased with their care and services provided.

The seven areas of noncompliance from the previous audit relating to long term care plans being completed within the required timeframes, care plans reflecting the current and individual needs of the residents, behaviour management care plan for those in the dementia unit and behaviour charts not being evaluated have been addressed. In addition, previous shortfalls related to the food servery cabinet in the rest home, chemicals not being stored appropriately and the suitability of plants in a dementia care garden have been also addressed. There is one new area identified for improvement from this audit related to the reassessment of a resident who is requiring an increased level of care.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreting services if required. Staff provided residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained. When complaints have been received, these are investigated, and the information related to these is recorded. Residents said they had been informed about the complaint process.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The operator and facility manager are maintaining frequent and clear communication with all staff. There is always a qualified and experienced manager available. The quality and risk management systems are well established, and service delivery was being regularly monitored. Adverse events were being reliably reported and investigated to determine cause and prevention. People impacted by an adverse event were notified. The operator understands the obligation to make essential notifications and actions this when required.

Staff were being recruited and managed effectively. Staff training in relevant subject areas has been occurring regularly. There were adequate number of skilled and experienced staff on site to meet the needs of each resident group.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents' needs are assessed by the registered nurse. The registered nurse oversees the care provided to the residents. Senior care staff are on duty 24 hours, seven days a week. The facility manager and registered nurse are supported by a designated general practitioner, other health care professionals and care staff. On call arrangements for support from the registered nurse is in place. Shift handovers and communication sheets guide continuity of care.

Residents' records reviewed showed that care plans are individualised based on a range of information. InterRAI re-assessments and care plan evaluations are completed as per the schedule developed. Residents able to be interviewed reported being informed and participating in their care planning and evaluation and were satisfied with the care provided.

The planned activity programme provides a variety of individual and group activities and residents can maintain links with the community. A vehicle is available to take residents to appointments and for outings.

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

The food service meets the nutritional needs of the residents with special needs being catered for. Policies and procedures guide food service delivery supported by staff who have completed the required training. The kitchen was clean and tidy and meets the food control plan. Residents verified satisfaction with the meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness was on display. All internal and external areas of the home were being maintained as safe and fit for purpose. There have been no structural changes to the building since the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There were no restraint or enablers in use on the days of audit.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken with data analysed, trended and results reported back to staff and management.

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	1	0	0
Criteria	0	42	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Records and staff and resident interviews showed complaints are managed according to policy and Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The complaints register showed three complaints received since the previous audit. The documentation attached to these confirmed investigations occurred and that these were resolved to the satisfaction of the people involved. A resident interviewed was fully informed about the complaints process and said they had no hesitation in raising concerns or lodging complaints. They had experience of their complaint being taken seriously and said that action was taken immediately to address the matter. There have been no complaints received by the DHB or the Office of the Health and Disability Commissioner since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>The family communication records in the individual resident records reviewed verified that families were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services have not been required. Staff from other countries have been able to interpret for one resident who is from their same source country.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>At the time of this audit, there were 42 residents occupying the available maximum of 47 beds under the DHB ARC contract. The organisation also has DHB agreements for short stay/respite service and day attendance for people diagnosed with dementia. Fifteen of the residents on site were assessed as requiring rest home level care and 27 people, across two separate dementia wings, required secure care. One of the rest home residents was funded by the Accident Compensation Commission.</p> <p>There is a new facility manager. This person was initially employed as a receptionist/administrator in July 2019 and was appointed as the facility manager two months later in September. Although they have no prior experience in aged care or the health sector, this person is skilled in people management and quality and risk management systems. They are fully supported by the directors and company managers, two of whom are registered nurses. All clinical matters are managed by the onsite fulltime clinical manager. The company (Kaylex Care Ltd) has an overarching strategic/business and risk plan for the two facilities it operates, and each facility has a unique annual business plan. Review of the 2019/20 plan for Eastcare Residential Home showed that goals within it are monitored and updated by the company's senior management team. This team comprises the two owners, a general manager and an operations manager. The facility manager reports regularly to all members of the management team.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is an established quality and risk management system which includes policies and procedures. These are controlled and updated two yearly or as required to meet known safe practice. Residents said that they were consulted about any proposed changes in the service and kept informed at their monthly meetings.</p> <p>Quality data such as incidents/accidents and infections were analysed and collated by the RN every month. Statistical and narrative data was displayed in the staff room, any events were communicated at shift handover, and unwanted trends discussed at bi-monthly staff meetings. Documented evidence of corrective actions was sighted on incident/accident reports, on the internal audit tools where a deficit or gap is identified, in the hazards register, and in complaints documentation. The service also completes quality improvement plans when service deficiencies or opportunities to improve are identified.</p> <p>The organisation's annual quality plan, business plan and associated emergency plans, document actual and potential risk to the business, service delivery, staff and/or visitors' health and safety. Health and safety policies were compliant with the current legislation. Environmental risks were being communicated to visitors, staff and consumers as required through notices, or verbally, depending on the nature of the risk. For example, temperature checks were taken before entry to the home and requests to sanitise hands and don masks were happening for every visitor and staff. Review of staff meeting minutes showed that health and safety is discussed at least every two months. Any health and safety matters that arise in between time were written into the staff communications</p>

		book.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There were well known and established processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed that incidents were discussed at staff meetings. Adverse event data is collated and analysed monthly by the RN.</p> <p>Information about the number of events in each of the three areas in the home and a narrative summary were on display in the staff room. Staff confirmed that they are kept informed about incident and accident trends.</p> <p>Interviews and review of incident data on the days of audit confirmed that incidents are communicated at shift handover, and trends are discussed at staff meetings. Each resident's care record contained a summary of incidents which facilitates a ready review of risks.</p> <p>The owner is responsible for essential notifications and reporting and understood the statutory and regulatory obligations. There have been no incidents requiring notification to the DHB or Ministry of Health. The owner/director confirmed by telephone that appointment of the new facility manager and the RN were reported to the DHB and MoH.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Staff 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.</p> <p>Staff orientation includes all necessary components relevant to the role. A new caregiver reported that the orientation process prepared them well for their role.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Delivery of this was interrupted during the Covid-19 level 4 lockdown but the following training has occurred: Covid-19 precautions; handwashing; medication competencies; and mandatory training, which include: emergency procedures; health and safety; managing challenging behaviours; communication; and infection control.</p> <p>All 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. Of the 19 care staff, five have completed level 4, eight have completed level 3, four carers are newly employed and the other two have been in the role for more than ten years and have completed previous educational achievements.</p> <p>All staff working in the dementia care areas have either completed or are enrolled to complete the required dementia care unit standards 23920-2392.</p>

		The sample of staff records reviewed showed attendance at ongoing training and completion of annual performance appraisals.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7) is documented and implemented. The facility adjusts staffing levels to meet the changing needs of residents. Care staff reported there had been staff shortages during the Covid-19 level 4 lockdown because recruitment could not occur but that this had been addressed and there were now adequate staff available on each shift.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with absent staff replaced by existing staff doing extra hours.</p> <p>All the care staff on duty have a current first aid certificate.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A system for medicine management using an electronic system was observed on the day of the audit. The staff observed 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. Annual drug administration competencies are completed, and a record is maintained.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by the RN against the prescription. All medications were within current use by dates. Clinical pharmacist input is provided on request. The GP interviewed stated there have been no issues requiring her input since the electronic system was implemented. Any controlled drugs are checked prior to administration and are prepacked and checked by the RN. There is a locked medication room.</p> <p>Electronic prescribing includes the name of the GP, the date of the last medication review, photo identification and the date when the photograph was taken of the resident. Any allergies/sensitivities are clearly documented in red ink on the profile page or 'nil known' is documented to verify the resident/family has been asked about the allergies and/or sensitivities.</p> <p>There were no residents who were self-administering medications. The RN interviewed completes weekly medication administration audits and routine internal audits as per the audit schedule six monthly. The records of medication fridge monitoring are maintained and were within the recommended range.</p> <p>Any medication errors are reported to the RN and recorded on an incident form. The resident and/or the EPOA are</p>

		advised. There is a process to analyse any medication errors.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided by a cook on site. The cook interviewed explained his role and responsibilities. The food service is in line with Telarc requirements and the food safety inspection certificate was sighted with an expiry date of 11 January 2021. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines for older people. Food temperatures and fridge/freezers are monitored daily. The cook and kitchen hands have undertaken safe food handling training.</p> <p>A nutritional profile is undertaken for each resident on admission to the facility and a dietary profile developed. The personal preferences, any special dietary needs are identified and communicated to the cook and accommodated.</p> <p>The residents were observed enjoying their lunchtime meal. Residents were assisted by the care staff if needed with their meals. Residents confirmed they were happy with the meals provided.</p> <p>A previous noncompliance related to the surface of the food servery cabinet in the rest home dining room was in poor condition and posed an infection control risk. This has been fully replaced, as sighted at audit.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The records reviewed evidenced that records are resident focused, integrated and that continuity of care is promoted. The previous noncompliance related to the long term care plans not reflecting the current and individual needs of the residents and not all residents in the dementia unit having a behavioural management care plan that identified triggers and related interventions of the resident presenting with challenging behaviours. The sample of records reviewed evidenced that both of the areas for improvement have been appropriately addressed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Residents' records were randomly selected to review. The care plans reviewed were developed and implemented from the initial nursing assessment and initial admission information provided by the NASC service or referrer. The newly appointed RN is qualified to complete interRAI assessments. A RN who covers two facilities has been completing the interRAI assessments prior to this staff appointment. The long term and short term care plans reviewed are currently up to date.</p> <p>A range of equipment and resources was available appropriate to the two levels of care provided at Eastcare in accordance with meeting the resident's needs as per the DHB agreement requirements for rest home and dementia level care.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by an activities co-ordinator who has been in the role for one year and is currently enrolled and is completing the Level 4 diversional therapy New Zealand Qualification Authority education available. The programmes are developed for the rest home and the two secure dementia care services and displayed in each service area. Outings and links with the community are encouraged that are meaningful to the residents. An assessment 'My big story' and an activities questionnaire are completed by residents and/or family on admission. The activities co-ordinator from this information develops an individualised activities plan for each resident. A variety of activities is provided for residents in both of the services. The 24 hour activities chart which was a previous shortfall has now been addressed. These were implemented and completed in the dementia service residents' records reviewed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>The residents' records were reviewed and care plans sighted. Progress notes were completed in both the nursing and medical records. Care plan reviews and interRAI reassessments are planned six monthly as observed and discussed with the RN. Short term care plans are developed if and when an issue arises. The challenging behaviours interventions and outcomes documented in the dementia care resident's records reviewed, evidence that the RN has made the appropriate evaluations. These are signed and dated accordingly. This was a previous noncompliance which has been fully addressed. An area identified for improvement relates to a resident who is observed to be requiring higher level cares during this audit.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during</p>	<p>FA</p>	<p>A previous noncompliance related to residents' access to toxic substances. This has been rectified. Cleaning chemicals, soaps and other substances were securely stored.</p> <p>Staff were observed to be using PPE (masks, gloves and aprons) on the day of audit. They confirmed understanding of correct procedures for donning and doffing and said they changed in and out of uniforms on site.</p>

service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 01 December 2020) is publicly displayed.</p> <p>Visual inspection, records reviewed and interviews with one of the operators who was acting as maintenance staff confirmed that planned and reactive repairs and maintenance is ongoing.</p> <p>The previous noncompliance related to a noxious weed in the gardens outside one of the secure wings is now resolved. These plants were removed and maintenance staff have been diligent with ensuring the grounds are safe.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal and respiratory tract. The RN interviewed is the infection prevention and control coordinator and reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Results are displayed. Graphs are produced that identify any trends for the current year and comparisons against previous years and this is reported to staff and the management team. Benchmarking does not currently occur.</p> <p>Infection rates for the facility remain low despite several residents who have frequent infections due to current co-morbidities. Care plans evidence appropriate interventions and evaluations. An infection summary was in all residents; records reviewed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service was maintaining its philosophy and practice of no restraint. There were no restraints or enablers in use on the day of the audit. The service uses alternatives to restraint such as low-low beds or fall out chairs.</p> <p>Staff education in understanding and preventing restraint and safe use of enablers is ongoing.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery	PA Moderate	A sample of residents' records reviewed from both services were current and the individual care plans reflected the individual resident's needs appropriately. An observation was made of an immobile resident receiving cares provided by two care staff. This was discussed with the registered nurse (recently employed) who confirmed that the resident's progress was different to that expected but that the resident's condition had been stable. The resident's individual record was reviewed, and significant changes had been recorded but another referral had not yet been arranged.	A resident who has been at this facility for three years was re-assessed on the 15 May 2020; however, the outcome is not clearly documented. The interRAI and the updated care plan reflect that the resident's needs have significantly changed since the last assessment. The resident now requires two care staff with all cares and mobilisation. The needs of the resident are being effectively managed by the care staff; however, a referral for reassessment is needed for these higher level care needs to be fully addressed.	A referral for a reassessment by the needs assessment service co-ordinator is arranged as soon as possible for a resident now receiving a higher level of care due to increased needs.

plan.				30 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.