

# Ambridge Rose Villa Limited - Ambridge Rose Villa

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## 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 Q-Audit 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:** Ambridge Rose Villa Limited

**Premises audited:** Ambridge Rose Villa

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 26 March 2021 End date: 26 March 2021

**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:** 21

# Executive summary of the audit

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## 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

Ambridge Rose Villa has capacity to provide dementia level of care beds for up to 25 residents. There were 21 residents on the day of the audit. There was one resident who had a special dispensation and was being funded as requiring rest home level care. The service is operated by Ambridge Rose Villa Limited. The owner/chief executive officer (CEO) is the facility manager who is supported by the other co-owner/manager, nurse manager (NM) and chief operating officer (COO). There is one governance body and CEO for the three facilities they own. Residents and families spoke positively about the care provided. There have been no significant changes to the service since the previous audit.

This surveillance audit was conducted against a sub-set of 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 records, observations and interviews with management, staff, and a general practitioner.

There were no identified areas requiring improvement.

## 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. 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.

The complaints process meets the requirements of consumer rights legislation. A complaints register has been maintained.

## 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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Business strategic and quality risk management plan include the scope, direction, goals, values, and mission statement of the organisation. Monitoring of the services provided to the management is regular and effective. An experienced and suitably qualified person manages the service.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified, and mitigated. Policies and procedures support service delivery and 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.
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The nurse manager is responsible for the development of care plans with input from residents, staff, and family member representatives. Care plans are individualised, based on a comprehensive range of assessment, information and accommodate any new problems as they arise. Files reviewed demonstrated that the care provided and needs of the residents are reviewed and evaluated.

The planned activity programme provides residents with a variety of individual and group activities and maintains links with the community.

The medication management system complies with current legislation, protocols, and guidelines. Residents receive medicines in a safe and timely manner. Medications are monitored and reviewed as required by the general practitioner (GP). The service uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent.

All meals are cooked on site. Resident food preferences, likes, dislikes and dietary requirements are identified at the admission and updated as needed. A food control plan was in place.

## 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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There is a current building warrant of fitness. Trial evacuations are conducted as required.

## 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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The Service has policies and procedures that support the minimisation of restraint. Ongoing restraint and challenging behaviour training are provided. There were no residents using enablers nor restraint at the time of the audit. The dementia facility is secure and safe for residents.

## 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.
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The infection control programme is developed in consultation with the relevant key stakeholders. The environment is managed in a way that minimises the risk of infection to residents, staff, and visitors. The infection control coordinator (ICC) is responsible for monitoring infections, surveillance of data, trends and implementing relevant strategies. There was no infection outbreak reported since the last audit.

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	17	0	0	0	0	0
<b>Criteria</b>	0	42	0	0	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>The service has a complaints management policy and procedures in place that align with the Code. The service's complaint register is detailed regarding dates, timeframes, complaints, and actions taken. All complaints sighted in the register had been resolved. There had been zero complaints in 2020 and one (1) complaint in 2021. This complaint required involvement of the health and disability commission (HDC) and was resolved amicably.</p> <p>Complaints information is used to improve services as appropriate. Quality improvements or trends identified are reported to the staff. Residents and family are advised of the complaints process on entry to the service. This includes written information around making complaints. Family/whanau interviewed describe a process of making complaints that includes being able to raise these at the six-monthly residents' meetings, putting a complaint (which can be anonymous) in the suggestion box or directly approaching staff or the facility manager.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures. Personal, health and medical information is collected to facilitate the effective care of residents.</p> <p>There were no residents who required the services of an interpreter however staff know how to access interpreter</p>



<p>provide an environment conducive to effective communication.</p>		<p>services if required. Staff can provide interpretation as and when needed; the use of family members and communication cards when required is encouraged.</p>
<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>	<p>FA</p>	<p>The strategic and business plan includes the scope, direction, goals, values, and mission statement of the organisation. The board meet every two months and other issues are discussed as they occur on a regular basis. The strategic plan was reviewed in November 2020. The CEO reported that the service was certified for 24 beds, with four (4) beds over the age residential care contract 20 bed threshold and awaits to be approved for the 25th bed by the local district health board.</p> <p>The strategic and business plans are current. The documents describe annual and long-term objectives and the associated operational plans. There is one governance body and CEO for the three facilities they own. The NM, COO, and owner/manager report to the CEO. Monthly reports to the board showed adequate information to monitor performance is reported including potential risks, contracts, human resource and staffing, growth and development, maintenance, quality management and financial performance.</p> <p>The nurse manager is supported by the management team which consists of the owner/CEO (facility manager), owner/manager, and the COO. The management team meets every two months. All members of the management team are suitably qualified and maintain professional qualifications in management, finance, and clinical skills. The service is managed by staff who have vast experience and knowledge in the health sector. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The owner/CEO interviewed reported that there are ongoing repainting, renovations, and maintenance of the external secure gardens.</p> <p>The service holds contracts with the district health board (DHB), ministry of health (MOH) for young people with disability (YPD), provision of rest home care and respite services. There were 21 residents receiving services on the day of the audit. At the time of the audit there were 20 residents assessed as requiring dementia level of care and one resident under the age of 65 with a rest home level of care special dispensation in place. The service provides a day care programme for maximum of two residents for five (5) days a week.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	<p>FA</p>	<p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit programme, regular family/resident satisfaction surveys, monitoring of outcomes, clinical incidents and accidents including infections surveillance.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the board, management team and staff meetings. The NM reports weekly to the Owner/CEO and to the board every two months during their sitting. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to</p>

<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>address any shortfalls. Resident and family satisfaction surveys are completed monthly and evidence of this was sighted.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI long Term Care Facility (LTCF) assessment tool process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. These are managed by an external consultant who keeps the service updated on any recent changes. In interview conducted, staff confirmed that they have access to policies and procedures if required.</p> <p>The Owner/CEO and COO described the process for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The Owner/CEO is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.</p>
<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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up in a timely manner. Neurological observations are completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed, and reported to the management, respectively. There is an open disclosure policy in place. Any communication with family and general practitioner (GP) following adverse events and if there is any change in the resident's condition is recorded in residents' records. Family/whānau and the GP interviewed confirmed they are notified in a timely manner.</p> <p>The NM described essential notification reporting requirements, including for pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks and missing persons. They advised there have been no notifications of significant events made to the MOH since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes reference 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 adequately for their role.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the providers agreement with the DHB. Staff training is being provided. Most health care assistants (HCA's) have completed career force level four and two are currently doing level three training. Staff reported that they were currently receiving ongoing training to meet the needs of residents requiring dementia level of care. Staff performance is monitored, and current annual performance appraisals were sighted in all files reviewed. The NM is competent and maintains annual competency requirements to undertake interRAI assessments. Additional registered nurses are available to cover from other sister facilities.</p>
<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>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe delivery, 24 hours a day, seven days a week. The service adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when required. Care staff reported there were adequate staff available to complete the work allocated to them. Observations and review of a four -week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All shifts have a staff member on duty with a current first aid certificate and the NM cover during the day. There is always at least two staff members on duty 24 hours a day. The service has adequate staff to cover for any increased needs.</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>	<p>FA</p>	<p>The medication management system complies with current legislation, protocols, and guidelines. Residents receive medicines in a safe and timely manner. All medications are reviewed three monthly or as required by the GP. The service uses electronic medication system, Allergies are clearly indicated, and current photos uploaded for easy identification. PRN medication purpose of use and outcome documented and sighted. The medication and associated documentation are stored safely, and medication reconciliation is conducted by RNs when a resident is transferred back to service and reviewed by the GP. The service uses individual prepacked system. There were no expired or unwanted medications. Expired medications are returned to the pharmacy in a timely manner. Controlled drugs are stored securely in accordance with medicine management system requirements. Controlled drug register is current and correct. Weekly stock and six-monthly stock checks by pharmacist are conducted, records sighted. An annual medication competency is completed for all staff administering medications and medication training records were sighted. The RN was observed administering medication safely and correctly. EPOA/Family kept informed if any change in medication.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>Meal services are prepared on site and served in the allocated dining room. The service employs two cooks and kitchen staff. The residents have a dietary assessment completed on admission which identifies nutritional requirements, likes, and dislikes communicated to the kitchen including any recent changes made. Diets are</p>

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>modified as required and the cook confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly, and supplements are provided to residents with identified weight loss issues. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly seasonal menu in place. The kitchen and pantry were sighted and observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is completed. The residents and family interviewed acknowledged satisfaction with the food service. Snacks and drinks are available for residents who wake up during the night on a 24-hour period. Food safety certificate valid and sighted.</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>	<p>FA</p>	<p>Documentation, observations, and interviews verified the provision of care provided to residents met assessed needs and desired outcomes. The care and interventions are regularly evaluated to ensure set goals are achieved. Variances are attended to and communicated to the care team. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed as per policy. Monthly observations are completed and are up to date, weight, blood pressure monitoring and blood glucose monitoring. Behaviour management plans are developed with multi-disciplinary input and describe types of behaviour, possible triggers, and interventions (Refer to 1.3.3 Tracer) The NM and the GP initiate any specialist referrals to the mental health services.</p> <p>Short-term and long-term care plans document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity, nutrition, and behavioural changes. Care staff interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions, evident by physical handover session observed.</p> <p>There are adequate links as appropriate with other services and organisations to support dementia level of care residents. EPOA /Families interviewed were satisfied with the information provided about the support available to residents in the community. confirm care delivery and support by staff is consistent with their expectations, they were kept informed of any changes to resident's health status. Resident files sampled recorded communication with EPOA/ family.</p> <p>A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs. Staff confirmed they have access to the supplies and products they needed. There is adequate PPE in place.</p>
<p>Standard 1.3.7:</p>	<p>FA</p>	<p>There is a full range of social activities that are available on the weekly programme for all residents to participate in.</p>

<p>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>Activities planned and implemented by qualified diversional therapist assisted by activities coordinator. All residents are assessed and invited to participate in specific activities that are appropriate for their level of ability and interests. The activities are used to facilitate emotional and physical wellbeing. The activities can either be individual or group activities conducted under the guidance of the staff. There were documented evaluations on the residents' participation and the outcomes that residents are achieving from these. The activities provided are individualised to meet the needs for people living with dementia. The residents were observed participating in a variety of activities on the audit day. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. Activities plans are evaluated every six months and integrated in the care plan.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented on each shift by care staff in the progress notes. The NM documents in progress notes daily and as necessary. All noted changes by the care staff are reported in a timely manner.</p> <p>Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals is completed, the evaluations are carried out by the NM in conjunction with family, GP, and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified EPOA /resident as appropriate are included and informed of all changes.</p>
<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>There have been no changes to the facility since the last audit. The current building warrant of fitness was sighted, and it expires 9 March 2022</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	FA	<p>Trial evacuations are completed every six months as required and the last fire drill was conducted on 25 March 2021. Records of staff attendance are maintained. There is an approved emergency evacuation plan.</p>

<p>Consumers receive an appropriate and timely response during emergency and security situations.</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>	<p>FA</p>	<p>The surveillance programme is defined and appropriate to the size and scope of the service. All infections are recorded in the residents' files using the nosocomial infection data collection form. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Results of the surveillance data is shared with staff during shift handovers, at monthly staff meetings and management meetings. Evidence of completed infection control audits were sighted.</p> <p>Staff interviewed confirmed that they are informed of infection rates as they occur. The GP is informed within the required time frames when a resident has an infection and appropriate antibiotics are prescribed for all diagnosed infections. There has been no outbreak since the last audit. A pandemic plan is in place and adequate personal protective equipment was sighted. Staff, residents, and families are updated on regular Covid-19 latest information.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The organisation's 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 for Ambridge Rose Villa. On the day of audit, no residents were using restraints, and no residents were using enablers. Environmental restraint is monitored, there is a secure gate. Access is controlled on entry and exit by staff with access control cards at the point of entry/exit after the visitor has pressed the intercom.</p> <p>No access or exit is permitted without staff in attendance. Family/whanau can go out and come back freely, residents can walk around within the facility garden in secure and safe passage.</p> <p>The NM provides support and oversight for enabler and restraint management in the facility, and demonstrated a sound understanding of the organisation's restraint policies, procedures, practice, and responsibilities. The NM confirmed restraint is used as a last resort when all alternatives have been explored. Staff receive ongoing education on the use of restraint and challenging behaviours. Staff interviewed demonstrated awareness on the difference between a restraint and enabler.</p>

## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.