# Orongo Lifecare Limited

## 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 Health Audit (NZ) 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Orongo Lifecare Limited

**Premises audited:** Orongo Rest Home

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

**Dates of audit:** Start date: 7 March 2015 End date: 7 March 2015

**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 |
|  | 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

Orongo Rest Home provides rest home and secure dementia level of care for up to 46 residents. On the day of audit there were 42 residents. The residents interviewed provided positive feedback about the care and support provided. The service has made commendable progress in the actioning of the shortfalls identified at the previous audit.

This unannounced surveillance audit was conducted against the required sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family/whanau, management, staff and a general practitioner.

This is the second unannounced surveillance audit to review the services progress of the 11 shortfalls identified at the last surveillance audit in March 2014. The previous certification audit against all of the relevant Health and Disability Standards identified two areas for improvement, with these being evidenced as fully addressed in the March 2014 surveillance audit. The March 2014 unannounced surveillance audit identified areas for improvement related to open disclosure; documentation of complaints; facility manager’s education; reporting incidents/adverse events; documentation in resident records; and human resource processes. In the continuum of service delivery standards there were improvements required in care planning; ensuring interventions meet the resident’s needs; having individualised activities plans for residents. There were a number of medication management practices that required improvement. This included ensuring staff have current medication competencies.

This surveillance audit identified that 10 of above shortfalls have been fully addressed with the improvements now imbedded into practice. No shortfalls have been identified with one of the above areas being partially addressed and still requiring further implementation. There is further improvement required related to ensuring short term care plans are consistently used to address the acute or temporary needs of residents.

## Consumer rights

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| 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. |

Staff communicated effectively with residents and provided an environment conducive to effective communication. The service promoted open and honest communication with residents, and where appropriate family/whanau.

Complaints management was undertaken to meet policy requirements. The service had a documented complaints management system which was implemented. There were no outstanding complaints at the time of audit.

## Organisational management

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| 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. |

The organisation's values, goals and mission statement have been identified in the business plan which was reviewed annually at board level. This document identified how services were planned and coordinated to meet residents’ needs.

The quality and risk plan showed the measures taken to deliver services in a safe and effective manner. The service implemented corrective action planning to manage any areas of concern or deficits found. Quality management reviews included internal audit process, complaints management, incident/accident, risk and infection control data collection. Quality and risk management activities and results were shared among all staff and with residents, as appropriate.

The service implemented the documented staffing levels and skill mix to ensure contractual requirements were met. Effective human resource management, orientation and ongoing education processes were implemented.

## Continuum of service delivery

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |

The residents received timely, competent, and appropriate services that met their assessed needs and desired outcome/goals. Staff have current practising certificates. The residents were admitted within 24-48 hours with the use of standardised risk assessment tools. Short term care plans were not consistently developed when acute conditions were identified. The long term care plans were reviewed six monthly.

The contents of the hand over were comprehensive and staff have demonstrated good knowledge regarding resident’s current condition and treatment.

The planned activities were appropriate to the needs, age and culture of the residents. Activity plans were personalised and reflected the assessed needs and preferences of the resident. The 24-hour activity plans were comprehensive.

The medicine management system complied with the current legislative requirements. All reviewed medication charts reflected three monthly review conducted by the GP. There were no expired or unwanted medications. The controlled drug register was current and correct.

The service provided meals that met the individual food, fluids and nutritional needs of the residents. The food was well-presented. The weights were stable. Modified diets were provided and extra fluids were given during summer.

## Safe and appropriate environment

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| 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. |

There is a current building warrant of fitness. There have been no changes to the building that have occurred that would require changes to the approved evacuation scheme.

## Restraint minimisation and safe practice

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| 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. |

There were no residents on restraint or enablers. The policies and procedures were in place in the use of restraint. The staff had demonstrated good knowledge about restraints and enablers.

## Infection prevention and control

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| 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. |

There was monthly surveillance of infections recorded. The infection data was recorded, analysed and reported to staff and management. Where trends were identified the staff implemented actions to reduce infections.

## Summary of attainment

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

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| **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 | 16 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 1 | 0 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **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 previous audit identified a shortfall at 1.1.13.3. It was identified that whilst there is a separate register for the recording of concerns and minor complaints this was not being completed. A concern or minor complaint was noted to be a ‘complaint that can be remedied to the complainant’s satisfaction at the time the complaint is received and the complainant advises the issue does not need to be pursued further’. It was evidenced that four of six respondents in the resident satisfaction survey (July 2013) identified their concerns ‘could have been managed better’. The improvement required to ensure minor complaints and concerns are documented as per the organisations policy is now addressed. Complaints management was implemented to meet the sighted policy requirements. As confirmed during staff and family/whānau interviews, complaints management was explained during the admission process. Interviews confirmed that the open door policy operated by management made it easy to discuss concerns at any time. All complaints were documented and followed up by the manager and/or the clinical manager as shown in the complaints register sighted. Staff confirmed during interview that they understood and implemented the complaints process for written and verbal complaints that occurred. The manager used the information to improve services as appropriate. The residents and family report that the complaints process was easy to access and the manager can be contacted about any concerns they have. One family member was dissatisfied with some elements for their relatives care, and said that they may put in a complaint regarding this. This was not reflective of a systemic issue, with all other residents and family highly satisfied with the care and services provided at Orongo.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The previous audit identified an area for improvement at 1.1.9.1 to ensure open disclosure occurs in a timely manner for all applicable events. Records were available to demonstrate this. It was identified that open disclosure was not able to be evidenced in the resident files applicable to incident reports reviewed at random during the previous audit. This is now addressed. The family/whanau confirmed they were kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented in the family communication sheets, on the accident/incident form and in the residents' progress notes. The service promoted an environment that optimises communication and staff has received education related to appropriate communication methods. The service has not required access to interpreting services for the residents to date. Policies and procedures were in place if the interpreter services are needed to be accessed.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The previous audit identified a shortfall at 1.2.1.3. It was identified that the facility manager was attending education/in-service. However they were unable to demonstrate they had completed at least eight hours of education in the last twelve months relevant to the management of an aged care facility (as required by the contract with the DHB). The required improvement to ensure the facility manager participates in at least eight hours related to management of aged care facility is now addressed. The business plan clearly identified planned and coordinated approaches to ensuring services offered are meeting the needs of residents. The service has a 15 bed secure dementia unit and 31 rest home beds. At the time of audit there were 12 residents living in the dementia unit and 30 in the rest home wings. The manager has delegated responsibilities to keep the director informed of any issues or concerns that impact the business. There is a monthly governance meeting which is attended by the director and manager, which covers key components of service delivery and goals within the business plan. The manager reports there is also weekly informal feedback to the director.The manager is an enrolled nurse who has suitable qualifications and experience in the management of an aged care service. The manager had job descriptions which identified their experience, education, authority, accountability and responsibility for the provision of services. The facility manager evidenced in excess of eight hours of education in the past 12 months related to the management of an aged care facility. The manager is a member of an aged care association and receives continued updates and education related to the management of aged care services. The manager is supported onsite by a clinical team which includes registered nurses, as well as the organisational quality and risk management team. Interviews with residents and most family/whānau confirmed that their or their relative’s needs were met by the service. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Staff are actively involved in the quality programme and demonstrated an understanding of what the organisation aims to achieve. The quality committee meeting minutes were made available to staff. Staff participated in the monthly policy review reading process. Staff participated in service meetings and raised any issues, so improvements can be made. The quality plan for 2015 contained the goals to achieve the organisational goals and vision of the organisation. There were measurable outcomes documented in the quality plan. Achievement against the goals was reviewed at the monthly governance meeting. Staff confirmed they understood and implement the quality and risk management systems.All policies and procedures sighted were up to date, reflected current good practice and met legislative requirements. The organisation currently reviews all documents in a two yearly cycle. The document control system ensured that obsolete documents were removed from use. The organisation had a documented quality and risk management plan which identified risks and showed the strategies in place to manage risks. All potential and actual risks were reported at board level and reviewed regularly. Clinical risks were discussed monthly at staff meetings as confirmed in meeting minutes sighted, and confirmed by staff. There was an up to date hazard register and the process for reporting hazards was understood by staff interviewed. Quality data collection and analysis was maintained by the service and evaluation of results shared with staff and management. Quality improvements were put in place where indicated. Regular audits were undertaken and corrective action planning was put in place to manage any deficits found. Staff confirmed that all follow up actions were discussed during handover and at regular staff meetings. Data was collected, trended, reviewed and evaluated for all key components of service (complaints, incidents and accidents, health and safety, hazards, restraint and infection control). Occupational safety and health practices were described in policy implemented and included staff training and education. Staff, resident and family/whānau confirmed any concerns they have were addressed by management. |
| 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 | The previous audit identified a shortfall at 1.2.4.3. It was identified that medication related incidents or adverse event reports were not being documented by staff. This included where medications were not signed as being given as prescribed (or noted as with-held or refused).The medication policy noted ‘it is mandatory for staff to report any discrepancies, errors or omissions’. The required improvement to ensure all types of incidents are being reported investigated and followed up in a timely manner as per the organisations policies is now addressed. The service now has a medication error log that details the event and actions taken to reduce medication errors. Incident reporting as described in policy was implemented by the service. This included the provider’s statutory obligation related to essential notification reporting. Members of the management team verbalised their understanding of this reporting process. There have been no issues that have required reporting to authorities since the last audit. All adverse, unplanned or untoward events were recorded, reported and analysed, this included medication errors. Information was used as an opportunity to improve services where indicated. For example there was specific documentation related to the medication incident reporting and implementing measure to reduce falls for residents.  |
| 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 | The previous audit identified shortfalls at 1.2.7.3. It was identified that records evidencing reference checks or interview processes were not available in two of five staff files sampled where the staff member had been employed between December 2010 and July 2013. It was also identified that police checks were not being undertaken despite new employees providing written consent for this to occur as a component of the employment process. Police checks were noted as being required in the organisations policies. The master list identified when staff performance appraisals were due. Three of six staff files sampled at the previous audit did not contain a performance appraisal completed in the last twelve months. The master register identified these had been attended but were unable to be located during the last audit. The required improvement to ensure all human resource practices comply with the organisations policies is now addressed. Staff that required professional qualifications have them validated as part of the employment process and ongoing annually. Annual practicing certificates were sighted for all staff that require them. Policies and procedures implemented identified that most good employment practices were met., this included documented evidence of reference checking and police vetting. This was confirmed in the staff files reviewed. Signed job descriptions and employment contacts were sighted in all staff files reviewed. Staff ongoing education covered all areas of service provision and was clearly documented under each staff member’s name. The annual in-service education calendar and off-site education undertaken by staff was related to the roles they undertake. All RNs and most caregivers hold current first aid certificates. The care staff who work in the secure dementia unit have completed the required qualifications. Interviews with residents and family/whānau members identified that residents’ needs were met by the service. No negative comments were voiced on the day of audit. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The organisation had a clearly documented process to determine staffing requirements which was implemented. This was confirmed by a review of staffing rosters and the daily management report sheets sighted. Staffing levels and skill mix exceeded the contractual requirements with the DHB for rest home and secure dementia level of care. The layout of the service was considered in the rostering. There is an RN, EN or senior caregiver on duty seven days a week. Staff are replaced for sick leave and annual leave. As required the service utilises a nursing bureau to fill vacant shifts. Staff confirmed that they had enough time on all shifts to meet residents’ needs. There was adequate staff that undertakes cleaning, laundry, activities and kitchen duties.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The previous audit identified shortfalls at 1.2.9.1. It was identified that staff were not documenting the time entries were made in clinical notes and documentation in clinical records were not always complete or timely. These improvements have now been addressed. The residents’ files reviewed identified that information is managed in an accurate and timely manner. The resident’s progress notes recorded the date, time, name and designation of the staff member. |
| 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 service has a medicine management system that had complied with the current legislative requirements. All reviewed medication charts had reflected three monthly review conducted by the GP. All discontinued medications were signed and dated by the GP, allergies and sensitivities were documented and there were photos sighted in all reviewed medication charts.The RN and the caregiver during the witnessed medication rounds had demonstrated compliance with the medication administration policies and procedures of the service. All staff who administer medications have current medication competencies as evidenced in the files.There were no expired or unwanted medications. Expired medications were returned to the pharmacy in a timely manner. The controlled drugs register was current and correct. There were no residents who self-administered their medications. The self-administration policies and procedures were in place.The medicine fridge was monitored daily. There were sharp bins in the medication rooms.Medication management practices complied with the current accepted practice and legislative requirements. The documented medication management system have met the legislative requirements of the current medicines regulations. The previous areas for improvements have been fully implemented. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The service provided meals that have met the individual food, fluids and nutritional needs of the residents. The foods served during lunch have met the recognised guidelines in the aged care sector. The foods were well-presented and has adequate portion. The interviewed residents have verbalised that they have enjoyed the meals provided by the service. The weights in all reviewed resident’s files have reflected stable weights. Dietary profiles were kept in the resident’s files and a copy was kept in the kitchen file. The cook verbalised that extra fluids were provided for the residents during summer.Staff used clean technique when preparing meals. A cleaning schedule was implemented by the service. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in the reviewed resident’s file were sufficiently detailed and well-documented to address the assessed needs and desired outcomes. Interventions in managing other infections were documented in the progress notes and in the short term care plans. The long term care plans were resident-focused and the interviewed staff had verbalised that the documented interventions were easy to understand.Care plans were sufficiently detailed to guide staff in the provision of care. Care plans were updated in a timely manner. The previous area for improvements have been fully implemented. |
| Standard 1.3.7: Planned ActivitiesWhere 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. | FA | The service had provided activities that were appropriate to the needs, age and culture of the residents. The activities coordinator had developed the activity plans and had ensured that the residents were aware of the daily activities. All reviewed activity plans were personalised and had reflected the assessed needs and preferences of the resident. There were 24-hour activity plans for the residents in the dementia unit to guide staff in managing the residents in the dementia unit. The interviewed staff had verbalised that the 24-hour activity plans for the residents in the dementia unit were very useful to them. The activities coordinator had developed and implemented individualised activity plans for all residents in the rest home. The previous area for improvement has been fully implemented. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | The RNs had conducted six monthly evaluations in all reviewed resident files. The resident’s response to treatment was documented in the short term care plans and in the progress notes. There was evidence that the GP prescribed a different antibiotic when the resident has not responded well to the previous antibiotics. The resident’s response to the treatment was also discussed during the witnessed hand-over. The resolution of the acute infection was documented in the sighted short term care plan and in the progress notes.Long term care plans were sufficiently detailed that reflected the current needs of the residents. Short term care plans were not consistently developed and implemented when a resident developed an infection. The previous area for improvement has not been fully implemented.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness. There have been no changes to the building structure since the last audit that has required changes to the approved evacuation scheme.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The service conducted monthly surveillance for infections in the rest home and secure dementia unit. The service used standardised definitions of infections that were appropriate to the long term care setting. The infection and surveillance data for January 2015 recorded four urinary tract infections. Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes were acted upon, evaluated, and reported to relevant personnel and management in a timely manner. Analysis of the infection data identified that two of the infections were related to one resident. Actions were implemented to reduce the occurrence of infections for the resident. There were no infections recorded for this resident in 2015. The results of the surveillance data was displayed in the staff areas.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There were no residents on restraint or enablers. The policies and procedures were in place in the use of restraint. The staff had demonstrated good knowledge about restraints and enablers.  |

# 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 1.3.8.2Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Evaluations were documented in both progress notes and short term care plans. The resident’s response to treatment was evidenced in the reviewed resident’s files. | Short term care plans are not consistently developed and implemented when a resident developed an infection.  | Develop and implement short term care plans for all infections and other acute conditions.180 days |

# 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.

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| No data to display |

End of the report.