# Munro Resthomes Limited - Mt Maunganui

## 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 and Disability Auditing New Zealand 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:** Munro Resthomes Limited

**Premises audited:** Malyon House

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 4 March 2016 End date: 4 March 2016

**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:** 54

# 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

Malyon House provides rest home and hospital level care for up to 57 residents and on the day of the audit there were 54 residents. The service is managed by a facility manager and a clinical manager. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a 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 and interviews with residents, family, management and staff.

The previous certification audit identified no shortfalls. This surveillance audit identified the following areas which require improvement including adverse event reporting, care planning, medication, and enabler consent.

## 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. |

Residents and families interviewed report that they are kept informed. Residents and their family/whānau are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

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

Services are planned and are appropriate to the needs of the residents. A facility manager and clinical manager are responsible for the day-to-day operations of the facility. Quality and risk management processes are established. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice and meeting legislative requirements. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty.

## 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. |

Initial assessments are completed by a registered nurse. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided.

## 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. |

The service displays a current building warrant of fitness.

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

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service has one resident who voluntarily uses an enabler and six residents assessed as requiring the use of restraint.

## 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. |

The type of surveillance is appropriate for the size and complexity of the service. Effective monitoring is the responsibility of the infection control coordinator. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.

## 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 | 10 | 0 | 6 | 0 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 6 | 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 service has a complaints policy that describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with all seven residents (three at rest home level of care and four at hospital level of care) and family members confirmed that they understand the complaints process. They also confirmed that the manager and staff are approachable and readily available if they have a concern.  Nine complaints have been lodged in the past twelve months. The complaints register includes all information and correspondence related to each complaint. Times frames for responding to each complaint were met and all nine complaints have been resolved. Two complaints referred to HDC have now been investigated and closed. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families. The admission pack gives a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/health issues arises. Four family members interviewed (two rest home level and two hospital level) stated they were kept informed of any change in their family member’s health condition.  The service has policies and procedures available for access to DHB interpreter services for residents. The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Malyon House is owned and operated by the Cavell Group. The service provides rest home, hospital and long term chronic level care for up to 57 residents. Eight beds in one wing are rest home level care only and the remaining 49 are dual purpose beds. On the day of audit there were 54 residents (24 residents receiving rest home level care, including one respite resident, and 30 receiving hospital level care). This also includes two residents receiving care under the long term chronic contract (one at rest home level care and one at hospital level care). All other residents were under the Aged-Related Residential Care contract.  Malyon House has a business/strategic plan, philosophy of care and mission statement which links to the organisation’s strategic plan and is reviewed monthly with the directors. The facility manager reports to the director regularly on a variety of operational issues.  The facility manager is an enrolled nurse (EN) who has been in this role for 20 years. She is supported by a clinical manager /RN who has been in this role for five months.  The facility manager has completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Quality and risk management systems are in place. Interviews with all staff (seven care assistants working across the rest home and hospital, two registered nurses, a cook, a diversional therapist and a physiotherapist) confirmed their understanding of the quality and risk management programmes.  There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. A document control system to manage policies and procedures is in place.  The quality and risk management programmes includes an internal audit programme and data collection, analysis and review of adverse events including accidents, incidents, infections, wounds and pressure injuries. A corrective action process is implemented where opportunities for improvements are identified. There is evidence of results being communicated regularly to care staff in meeting minutes and on staff notice boards. Quality data is being shared at all site staff meetings.  The health and safety programme includes policies to guide practice. Staff accidents and incidents and identified hazards are monitored.  Falls prevention strategies are in place including the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls. Selected residents wear hip protectors to reduce injury from falls and sensor mats are in place to reduce the number of falls. |
| 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. | PA Low | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective actions. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is trended and linked to the quality management systems. A monthly incident accident report is completed which includes an analysis of data collected. Quality and senior team meeting minutes review the analysis of incident and accident data and corrective actions. Accident/incident forms sampled from January and February 2016 included registered nurse assessment following an event, but not all residents had appropriate RN follow up documented.  There was evidence that the service has complied with essential notification requirements since the last audit. |
| 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 | There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioners practising certificates including GP, pharmacist and physiotherapist. Nine staff files were reviewed (the facility manager, clinical manager, one maintenance person, one cook, one cleaner, two registered nurses and two care assistants). Evidence of signed employment contracts, job descriptions, orientation and training were sighted. Annual performance appraisals for staff are conducted for all employees. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with care assistants described the orientation programme that includes a period of supervision.  The service has a training policy and a scheduled in-service education planner. The in-service schedule is implemented and attendance is recorded. There are implemented competencies for registered nurses including (but not limited to); medication, restraint and the use of a syringe driver. |
| 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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. At least one registered nurse is on site at any one time. Extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents |
| 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. | PA Low | Ten medication charts were reviewed (four rest home including the resident admitted on the LTC contract and six hospital level of care). The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. The facility uses a computer base medication system. Registered nurses are responsible for administering medicines. All RN’s are medication competent and have received medication management training. The facility uses a robotic pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medication charts are written by the medical practitioners; however, not all charts evidenced the resident’s allergy status. There was evidence of three monthly reviews by the GP. One resident was self-medicating on day of audit and the management of this compiles with organisations policy on self-medication. Standing orders are not used.  Medication fridge temperatures are monitored and are within an acceptable range. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared and cooked on site by the cook. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the cook works closely with the clinical manager or RN on duty. The kitchen staff have completed food safety training. The cook follows a rotating seasonal menu. Residents dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. The menu was last reviewed by a dietitian in 2011 and by the owner (RN) in 2015. Advised by the service that the menu has not changed and therefore a menu review has not been required. The temperatures of refrigerators, freezers and cooked foods are recorded remotely with an alert in place for any issues. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Registered nurses (RNs) and care assistants follow the care plan. The RNs report progress against the care plan at least daily, or more frequently if needed. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g. to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical and dressing supplies. Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.  Six wounds were reviewed. There were three hospital residents with wounds (one stage II pressure injury, one skin tear and one tumour), and three rest home residents with wounds (one skin tear, one venous ulcer and one surgical wound). Each wound had a wound assessment completed and monitoring and wound management plans were in place. All wounds have been reviewed at appropriate times. The RNs have access to specialist nursing wound care management advice through the district nursing service.  Interviews with registered nurses and care assistants demonstrated an understanding of the individualised needs of residents. Fluid charts are comprehensively completed as required. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | A qualified diversional therapist is employed full-time to coordinate the activities programme for all residents. Assistance is provided by an activities coordinator. Each resident has an individual activities assessment on admission. From this information an individual activities plan is developed. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. There is a comprehensive seven day programme provided. There is a high level of community involvement which includes local schools and volunteers. All long term resident files sampled have a recent activities plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Residents and families interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan was not consistently reviewed at least six monthly or earlier if there is a change in health status (link 1.3.3.3). Care plan reviews are signed by the RN. Long-term care plan reviews did not contain an evaluation of stated goals. There is at least a three monthly review by the GP. Short-term care plans were transferred to the long-term care plan if the problem was ongoing as sighted in resident files sampled. Where progress is different from expected, the service does not consistently respond by initiating changes to the care plan (Link 1.3.6.1) |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness which expires 5 August 2016. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There has been one outbreak since the previous audit. There was documented evidence that this was handled appropriately and correct notification occurred. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | PA Low | There are restraint minimisation and safe practice policies which are applicable to the service. Guidelines of the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register. There are currently six hospital residents using restraint and one hospital resident using an enabler. Documentation was reviewed for the resident using an enabler. Not all necessary documentation was fully completed. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | The clinical manager advised that a registered nurse (RN) undertakes an initial assessment and ongoing clinical review following any accident or incident.  However, on reviewing incident reports for December through to February 2016, seven of twelve were completed and evidenced that appropriate and timely clinical follow up had been conducted for residents post incident. | Five of twelve residents who had had a fall, had not had neurological observations fully completed according the organisational policy. | Ensure that neurological observations are fully completed, according to the organisational policy, for all residents following an unwitnessed fall.  60 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | The medical officer prescribes all medication to be administered and notes any medication allergies on the prescribing sheet. Two of ten medication charts reviewed had the allergy status documented. | Eight of ten medication charts reviewed (four rest home and four hospital) did not document the allergy status of the resident. | Ensure that the allergy status is documented on the medication chart.  60 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | The registered nurse completes initial assessments and an initial care plan on admission. In the files sampled, interRAI assessments where completed for all residents requiring interRAI assessments but not all interRAI assessments were completed in the required time frames. Long-term care plans were completed within 21 days of admission. | One of three hospital residents admitted since 1 July 2015, did not have the interRAI assessment completed within 21 days of admission | Ensure that all new admissions have an interRAI assessment completed within 21 days of admission.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | The registered nurse develops a plan of care based on interRAI assessments and other nursing assessments. Long-term care plans were current in one rest home and two hospital resident files reviewed. | Interventions noted in the progress notes were not documented in the care plan for one rest home resident with challenging behaviours. One hospital resident with identified pressure injury risk and changes in health care needs did not have these recorded in the long-term care plan. | Ensure that there are interventions documented in the care plan for all assessed care needs.  60 days |
| Criterion 1.3.8.2  Evaluations 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 | Short-term care plans were in use for acute changes in health status. The files reviewed evidenced that if the problem was not resolved, the issue was added to the long-term care plan. Evaluations of the long-term care plan were not all completed at least six monthly and did not indicate the degree of achievement or progress towards the stated goal. Two of five resident files sampled had not been at the facility for six months. | Three of five files (two hospital and one rest home resident), did not evidence that six monthly evaluations of long-term care plans had been conducted. | Ensure that all long-term care plans are evaluated at least six monthly (or earlier if there is a change in health condition) and include an evaluation of achievement or progress towards the stated goal.  90 days |
| Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | Residents using an enabler are to have a consent form signed and a care plan documented detailing the care required whilst using the enabler. The consent form and care plan for one resident using an enabler had not been fully documented. | One resident using an enabler did not have the risks associated with the use of the enabler documented on the consent form and there was no enabler care plan. | Ensure that all enabler consent forms are completed fully and include the risks associated with the use of the enabler. Ensure an enabler care plan is documented, detailing the interventions to manage the identified risks and the care required when the enabler is in use.  90 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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End of the report.