# Logan Samuel Limited - Anne Maree Court

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Logan Samuel Limited

**Premises audited:** Anne Maree Court

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

**Dates of audit:** Start date: 18 November 2016 End date: 18 November 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:** 51

# 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** |
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|  | 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

Anne Maree Court is one of two facilities owned and operated privately by two owner/directors. Both rest home and hospital level care services are provided for up to 57 residents.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of organisational documentation, staff files and residents’ clinical files, observations, and interviews with residents, families/whānau, management, staff and a general practitioner. One owner/director was present for most of the audit.

Feedback from residents and families/whānau members was positive about the care and services provided.

There were no corrective actions to follow up from the previous audit and no areas identified for improvement in this audit.

## 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 family/whanau receive full and frank information which reflects the principles of the open disclosure policy. The resident and their family/whanau are involved in the care planning, decision making and consent processes. Where there is a valid advance directive, the staff act on the decisions. Interpreter service are available if required.

The service has a documented complaints management system implemented. There are two 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 owner/directors of Anne Maree Court ensure that business and strategic planning is in place to cover all aspects of service delivery. This is reviewed and updated annually as identified in the business plan. Quality data covers all key components of service delivery and is collected, reported and analysed monthly. Results are shared at all levels of the organisation and corrective action planning is put in place as required to make improvement where areas of concern of deficits are found. This allows effective, timely service delivery.

The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident surveys, restraint monitoring, and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and family/whānau, as appropriate.

The nurse manager is responsible for the day to day management of the service with a support team of registered nurses and experienced and educated caregivers. All staff receive appropriate education for the roles they undertake.

## 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. |  | Standards applicable to this service fully attained. |

The service works closely with the Needs Assessment and Service Coordination Service, to ensure access to the facility is appropriate and efficiently managed. Residents` needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day and are supported by care and allied health staff and a designated general practitioner. Shift handovers and communication sheets guide continuity of care. All residents have been assessed using the interRAI assessment process.

Care plans are individualised based on an integrated range of clinical information. Short term care plans are developed to manage any problems that might arise. All residents` records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Interventions are documented to meet the goals. Family members interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activities programme is supported and implemented by two trained diversional therapists. The programme provides group and one on one activities which are motivational and meaningful for the residents. A facility van is available for outings in the community.

Medicines are managed according to policies and procedures based on good practice and are consistently implemented using and electronic system and blister packed medicines. The registered nurses administer medications. Some senior care staff have completed competencies for checking out medications.

The food service meets the nutritional needs of the residents and those residents with special needs are catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety training provided on a regular basis. The kitchen is well organised, clean and meets food safety standards.

## 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 facility undertakes process to ensure the building warrant of fitness is kept up to date.

## 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. |

Policy states that enablers shall be voluntary and the least restrictive option to safely meet the needs of the resident. At the time of audit there is no restraint or enablers in use. Environmental restraint due to the front door having a key pad lock is safely managed by the service.

Staff undertake education related to restraint minimisation and they have a clear understanding of the difference between enablers and restraints and how to safely manage both.

## 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. |

Surveillance for infections is undertaken monthly. Results of surveillance is analysed to assist in achieving infection reduction. The infection surveillance results are appropriately reported to staff and management in a timely manner. Staff interviewed demonstrated a good knowledge of infection prevention principals and safe practice.

## 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 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 0 | 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 | Anne Maree Court implements group policies and procedures to ensure complaints processes reflect a fair complaints system. During interview residents, family/whānau and staff reported their understanding of the complaints process. Staff confirmed they document verbalised complaints so all issues are accurately reflected and followed up by the facility manager. All complaints are investigated by the facility manager and documentation is contained in a register which identifies the nature of the complaint, the dates received and the actions taken to address the complaint. Documented complaints information is used to improve services as appropriate. Complaints information is shared at staff meetings and with the directors as required. This is confirmed in meeting minutes sighted and during staff and management interviews. All complaints are also electronically recorded.Complaints forms are available to residents and visitors. There were two outstanding complaints at the time of audit. One is an internal complaint related to laundry services which was newly received and the other is a complaint which was made to the District Health Board (DHB) on the 31 October 2016. Documentation identifies that the programme manager from the DHB is fully investigating the complaint and at the time of audit the service was awaiting the results of the investigation.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Staff and management confirm residents’ rights to full and frank information. The service implements the open disclosure policy. Family/whanau contact is documented in resident files and confirmed during interview. Family/whanau 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 reviewed. There was also evidence of resident/family input into the care planning process.At the time of audit there is one resident with English as a second language. The service had processes in place to ensure the resident is able to communicate their needs and understand what staff are asking. There are pictorial and language flip charts to assist with communication and family/whanau are always available. The facility manager stated that interpreter services would be accessed if required. Staff are aware of how to contact approved interpreter services and stated they would use policy guidelines as required.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Anne Maree Court is one of two facilities privately owned and operated by two owner/directors. One director actively works within the business and the other manages the financial side of the business. Anne Maree Court has a business plan in place which is reviewed annually by the directors and monitored monthly by management to measure progress towards meeting set goals. There is a mission statement, goals and statement of purpose documented which guide the service provision to ensure planned, coordinated service delivery to meet the needs of the residents. On the day of audit, the service had 51 residents; twenty-five rest home level care and 26 were hospital level care. There is a facility manager in place who is experienced in aged care and has been in the role since 2014. He has over 10 years’ experience in aged care management. The facility manager is supported by a clinical nurse leader and a team of registered nurses. Both the facility manager and the clinical nurse leader hold current annual nursing practising certificates and they undertake appropriate ongoing education related to the roles they perform. One owner director is actively involved in service management and delivery. Accountability and responsibilities are clearly described in the job descriptions sighted. |
| 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 | Anne Maree Court has a quality and risk management system which is understood and implemented by service providers. This includes the update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and management, restraint management and complaints management.If an issue or deficit is found a corrective action is put in place to address the situation. Corrective actions are developed and overseen by the facility manager. Quality information is shared with all staff via the handover process on each shift and/or during staff meetings. This is verified during staff interviews and in documentation sighted. Reporting is undertaken electronically and both directors have access to all reports. The policies reviewed reflected legislative and good practice requirements. There is a system in place to ensure they are kept up to date. Quality data is trended against previously collected data. An annual review is undertaken by one director and the facility manager. This is linked to the quality and risk management system in place. Day to day analysis of data is monitored by the facility manager and corrective actions are implemented as required. The annual quality review is used to highlight both positive and negative findings. For example, there was a reduction in trends for incidents and accidents. Medication management, with a specific focus on pain management, was identified as an area for improvement and corrective actions put in place are clearly documented and included both on-site and off-site education for staff. Medication errors have been reduced. Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management. Staff verbalised examples of quality improvements made such as better understanding of the development of resident personalised goals when writing care plans following specific education. Actual and potential risks are identified using the quality and risk planning processes. Newly found hazards are discussed, monitored and managed via the health and safety processes in place. The facility manager oversees this process. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard register sighted was up to date. |
| 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 | Adverse event reporting, as identified in policy, is implemented by the service. The facility manager confirmed their awareness of the organisation’s requirement related to statutory and or/regulatory reporting obligations including the need to report pressure injuries under section 31 of the Health and Disability Services (Safety) Act 2001. Reporting forms are included in policy guidelines. Confirmation sighted related to an infection control outbreak in July 2016.Staff interviewed stated they report and record all incidents and accidents and that this information along with any corrective actions is shared at staff meetings as confirmed in minutes sighted. Documentation in residents’ files which include incident and accident forms identified that all issues reported had corrective actions put in place when required. Information is also entered electronically and the facility manager monitors corrective actions and documents outcomes. The owner/director is notified immediately of any serious adverse event. Family/whānau notification is clearly shown in documentation and confirmed during family/whānau interviews. Management reported during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Human resources management processes are conducted in accordance with good employment practices and meet legislative requirements. The service appoints appropriate service providers to meet the needs of the residents. Processes are clearly identified in the policies and procedures sighted. Staff file reviews show that all roles have job descriptions that describe staff responsibilities and accountabilities. Staff complete an orientation programme with specific competencies for their roles and covers all essential components of services provided. The orientation/induction process is completed for all new staff. Documentation in the staff files reviewed confirmed some competencies, such as medication management and fire and emergency management are reviewed annually.Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. Employment processes included reference checking and annual staff appraisals. (All appraisals were up to date for the staff files reviewed). There are 15 caregivers who have completed aged care qualifications and seven staff who are part way through obtaining their qualification. The facility manager is an assessor for the papers. Two RNs hold current interRAI competencies.The education calendar sighted for 2016 identifies that staff undertake training and education related to the roles they undertake. Topics covered in annual training and education relate to age care and health care services. Members of the management team also attend workshops and seminars specific to management related topics. Education occurs both on and off site. Resident and family/whānau members interviewed, identified that the service meets residents’ needs.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented process in policy which determines service staffing levels and skill mix. The facility manager confirms the rostered numbers of staff change according to resident acuity and need levels. Staff numbers sighted on four weeks’ rosters show that core staffing is maintained to meet residents’ needs and to comply with contractual requirements. Rosters identify that staff were replaced for sickness and annual leave. This was confirmed during interview with staff and management. Staff reported they had adequate time to complete all required tasks to meet residents’ needs. There is at least one registered nurse on all shifts.Resident and family/whānau members interviewed stated all their needs have been met in a timely manner. The service has dedicated cleaning, laundry and kitchen staff seven days a week. Two diversional therapists cover seven days a week activities. A maintenance person and a receptionist each work 40 hours per week. The facility manager works Monday to Friday and is on call as required.  |
| 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 implemented an electronic medication management system two years ago, and this system has significantly reduced medication errors. Only registered nurses administer medications. The medications are supplied by the contracted pharmacist in a pre-packed administration system. The pre-packed medications and the signing sheets are compared against the medicine prescription when received from the pharmacy and before administration. The GP conducts a medication reconciliation for each resident on admission to the service and when the resident has any changes made by other specialists. Safe medication management was observed at the time of this audit.The medications and medication trolley is securely stored when not in use. The controlled drugs are manged to meet legislative and aged care medication guidelines.The medication records randomly selected electronically were sighted for both rest home and hospital level residents. The records are legible, dated and signed by the general practitioner with registration numbers are included. Any discontinued medications are signed off and dated appropriately by the GP electronically.Medication competencies are completed for all staff who administer or who are involved with checking medications. The manager maintains records accordingly.There is one resident who facilitates safe self-administration of medicine. Protocol is followed for this rest home level resident and the general practitioner has authorised and consented to this occurring. This is evaluated six monthly. |
| 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 | A dietitian has reviewed the menu plans as suitable for older persons living in long term care. The menu plans are seasonal summer/winter. The menu plans are developed on a four-weekly cycle, rotational and varied. On admission to this service the registered nurses complete an initial nutritional assessment inclusive of dietary requirements and any special needs identified are documented. A copy of this assessment is provided to the cook. The cook interviewed takes into consideration any preferences, likes and dislikes to meet the needs of each individual resident. Special diets are catered for such as gluten free, high protein and diabetic diets.Home baking is provided for morning and afternoon tea. Additional beverage rounds included smoothies and some residents are provided with additional supplement high caloric beverages as required. Any prescribed supplements are recorded on the medication record.The residents and family interviewed reported satisfaction with the meals and fluids provided. The cook is responsible for all aspects of food procurement, production, preparation, ordering, storage, checking deliveries and disposal of any food. Current legislation and guidelines are available and are complied with. Fridge and freezer temperature recordings are undertaken and documented and meet requirements.The two cooks and kitchen hands have all completed relevant food hygiene and food safety training and this was verified in the staff personal records sighted.Care staff were observed assisting in the dining room at lunchtime. |
| 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 residents and family reported that staff have good knowledge and care skills. The GP expressed satisfaction with the care provided. The provision of services and interventions is clearly documented for the rest home and hospital level care residents. The care plans are individualised and personalised to meet the specific assessed needs of each resident and evidenced their physical, psycho-social, spiritual and cultural needs ware also considered. The care was flexible and focused on promoting quality of life for the residents. Residents and family reported high satisfaction with the care and all aspects of service delivery. |
| 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 | There are two fully trained diversional therapists who organise and implement the activities programme for the residents` at this facility. One diversional therapist interviewed has been at this facility for fifteen years and the other staff member for seven years.The activities programme for 2016 is available and was reviewed. Activities are planned for group and/or one on one activities. The programme is documented monthly and displayed weekly on the notice boards around the facility. Each resident also receives a copy individually. Attendance is voluntary and records are maintained by the diversional therapists. The activities are varied and flexible at times to suit residents. There are planned and spontaneous activities provided seven days a week.The programmed reviewed includes extra activities into the community and family are encouraged to participate anytime with the planned activities. Activities are modified according to the capabilities and cognitive abilities of individual residents. All activities are provided to develop and maintain strengths, skills and interests that are meaningful to the residents`. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluations are planned and conducted at least six monthly. There is evidence that the care is evaluated when there is a change in the resident`s condition. The short term care plans demonstrated that interventions are evaluated more frequently. The wound treatment plans reviewed have an evaluation of the treatment and condition of the wound at each dressing change.Where progress is different from expected, the registered nurses responded by initiating changes to the care plan or by using a short term care plan for any temporary changes. Short term care plans were observed in use in some of the rest home and hospital files reviewed. The residents and family reported satisfaction with the care provided by all care staff. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 3 November 2017. There is an approved fire service evacuation plan in place dated 6 June 2006 and no changes have been made to the facility footprint since this time. |
| 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 | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, upper and lower respiratory tract infections. The service has had one outbreak to manage in July 2016 and this was manged well. All notifications and records were maintained and were followed through as part of the audit process. The surveillance programme reviewed is appropriate for the size and nature of this aged residential care facility.The infection control coordinator a registered nurse reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced by the coordinator and displayed.Staff interviewed stated that they have a good understanding about the principles of infection prevention and control and education is provided regularly. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Policy states that the use of enablers is voluntary and the least restrictive option to meet the needs of residents. The service has documented environmental restraints which is recorded for the key pad lock on the front door. This is in place for security reasons. Information related to the key pad number is given to family/whanau and the resident upon entry to the service. Resident files contain a signed consent which stated they were fully informed of this prior to entry. At the time of audit there were no other forms of restraint or enablers in use. Ongoing staff education is undertaken so staff are aware of the safe use of restraint should it be required. This is confirmed during staff interviews where staff could verbalise their knowledge about restraint use. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
| --- |
| No data to display |

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

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

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

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

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| No data to display |

End of the report.