

Archer Care Facility 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 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](#).

The specifics of this audit included:

Legal entity: Archer Care Facility Limited

Premises audited: Archer Village

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 15 January 2015 End date: 15 January 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: 49

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	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

Archer Care provides rest home level care for up to 55 residents and the occupancy on the day of audit was 49 residents. Archer Trust is a charitable trust under the charities commission. The Trust includes a board of five trustees and the general manager completes a documented report to the board monthly. Archer Care has an established, documented and implemented a quality management system that is maintained and continually improved through the use of the quality policy, quality objectives, audit results, analysis of data, corrective action plans and management review. The general manager has been in the role for over 10 years and is supported by a nurse manager, quality manager and long serving staff.

The service has addressed three of the four shortfalls from the previous audit around adverse event management, assessments and medication management. Further improvements are required around aspects of care planning. This audit has also identified improvements required around activity care planning and wound care education.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Archer Care has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. The facility utilises an external benchmarking organisation. There is an active health and safety committee. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support and external training is well supported. The staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels meet requirements.

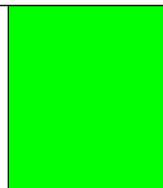
Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nurses are responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whanau. Planned activities are appropriate to the group setting. An appropriate medicine management system is implemented. Staff responsible for medicine administration are trained and have current medication competencies. Food service is provided on site by qualified staff who have completed food safety training. Residents' individual needs are identified, documented and reviewed on a regular basis and there is evidence of dietitian input into menu planning.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

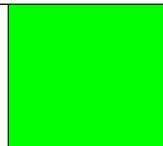


Standards applicable to this service fully attained.

The service has a current building warrant of fitness which expires on 1 February 2015.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service remains restraint-free. Staff are trained in restraint minimisation and challenging behaviour.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service implements effective outbreak management procedures.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	4	0	0	0
Criteria	0	37	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints procedure is provided to residents and their family within the information pack at entry. Complaint forms were available at the entrance to the building. Staff were aware of the complaints process and to whom they should direct complaints. Residents and family members interviewed confirm they are aware of the complaints process and they would make a complaint to the manager or other staff if necessary. There was a complaints register in place. A complaints folder was maintained with the documentation related to each complaint including sign off of the complaint. Six complaints for 2014 were reviewed and all included follow up and investigations.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. Three relatives stated that they were always informed when their family member's health status changes. Sixteen incident forms reviewed from December 2014 included documentation that family were informed. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau).</p> <p>Six residents and three family members interviewed stated they were welcomed on entry and were given time and explanation about services and procedures.</p>

		Resident meetings occur two monthly and family are invited to attend. The manager has an open-door policy.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Archer Care provides rest home level care for up to 55 residents and occupancy on the day of audit was 49 residents including four respite care residents. Archer Trust is a charitable trust under the charities commission. Archer Care is under the one of the trading companies. The Trust includes a board of six trustees (all directors) and they meet monthly. The general manager completes a documented report to the board monthly. Archer's loving life vision is incorporated into the Eden philosophy which challenges the traditional approach to residential care. Archer has established, documented and implemented a quality management system that is maintained and continually improved through the use of the quality policy, quality objectives, audit results, analysis of data, corrective action plans and management review. The general manager (GM) has been in the role for over 10 years. He has an MBA (Executive); B.Com; with 20-years management experience. The GM is supported by a nurse manager (RN), operations manager, quality manager and a team of long-serving staff. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service has a current business and a quality and risk management plan for 2014-2015. The service has continued implementing their quality and risk management system since previous certification. The service has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that is being implemented. There has been annual reviews of the QMP and overall quality and risk management programme. All staff are involved in quality improvements. The quality committee includes key staff from all areas of the service.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The monthly and annual reviews of this programme reflect the service's on-going progress around quality improvement. The internal audit schedule has been combined to include QMP and benchmarking monitoring. There is a register maintained of corrective actions, this is overseen by the quality manager.</p> <p>The service has a health and safety management system and this includes the identification of a health and safety officer. The monthly reports provided to staff</p>

		<p>via meetings and staff notice boards includes all quality data and the benchmarking indicator results. The service has ACC WSMP Tertiary level certification. The service has linked the complaints process with its quality management system. There is an infection prevention control register in which all infections are documented monthly. Internal infection control audits are planned and undertaken during the year.</p> <p>D19.2g: Falls prevention strategies such as sensor mats, vitamin D and a falls prevention exercise programme have been implemented. The physiotherapist and physio aide are also engaged in falls prevention.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Incident forms for December 2014 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. Reports were completed and family notified as appropriate. Quality and leadership meetings include discussion around incidents including falls management and preventative measures to be implemented.</p> <p>D19.3c: Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity.</p> <p>A copy of practising certificates including RNs, EN's, pharmacists, the dietitian, allied health and GPs were kept. There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (nurse manager, quality manager, DT, enrolled nurse, two caregivers).</p> <p>A comprehensive orientation programme is in place that provides new staff with relevant information for safe work practice. This was described by staff and records were kept. There is a documented in-service programme for education. Competencies were completed for insulin administration, medication administration and wound care. Compulsory study days are conducted in June each year. Staff are encouraged and supported to undertake external education. ACE training is supported.</p> <p>D17.8: More than eight hours of staff development or in-service education has been</p>

		provided annually. The organisation has a training framework for registered staff and another for caregivers. There is a staff training manual. An improvement is required in providing wound management training for clinical staff.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	There is a staffing levels policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Interviews with two caregivers, two enrolled nurses, residents and family members identify that staffing was adequate to meet the needs of residents. Shifts cross over for handover.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications are competency assessed annually and attend medication education - last provided in November 2014. All blister pack medications and other pharmaceuticals are delivered by the supplying pharmacy four weekly. The nurse manager or enrolled nurse check all medication on arrival and inform the supplier of any discrepancies. Medication storage, checks and administration meets requirements. Medication administration was observed and the staff member was compliant in the administration of medication. Ten medication charts sampled met legislative prescribing requirements for regular medication orders including warfarin prescribing and reason for use of as required medication which were previous audit findings that have now been addressed.</p> <p>Ten of ten medication drug charts sampled had photo identification and allergies/adverse reactions noted or nil known allergies. There was one self-medicating resident. Assessment and self-medication monitoring was in place. The medications for this resident were stored in a locked drawer in the resident's room. There is evidence of three monthly GP reviews on the medication charts. Internal medication audits are conducted (December 2014).</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	Archer Care provide buffet style dining/meals to residents which are prepared and cooked onsite. There are four weekly summer and winter menus with dietitian review (April-2013). All diets are catered for including diabetic and soft. Lunch and tea meals are provided in the main dining room. The service has a buffet style meal system whereby residents are able to have choice and serve themselves their own meals. Advised by staff that this continues to be a positive initiative providing residents with more choice and independence. Residents interviewed had positive feedback about the meal service. There were hot food temperatures taken at each

		meal service and these were recorded. Special eating aids were provided as assessed to promote independence. Resident dietary profiles and likes and dislikes were known to food services staff and any changes were communicated to the kitchen via a dietary profile form. Staff were observed wearing appropriate protective clothing. Fridge temperature monitoring was recorded daily. Staff have received education in food safety (June 2014). The kitchen has a HACCP approved food safety programme certification that expires 31 May 2015. Weekly resident forums and two monthly formal resident meetings allow for the opportunity for resident feedback on the meals and food services generally. Interviews with residents indicate that meals were enjoyed. The residents are given menu choices daily and there is a second option available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	The previous audit identified that challenging behaviour assessments had not been conducted for two residents with identified behavioural issues and wound assessments had not been conducted for four residents with wounds. This has now been addressed. The service has documented evidence that wound assessments have been completed and therefore this issued has now been addressed.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	The previous audit identified that three of eight care plans reviewed did not reflect all the interventions and care requirements needed to guide staff in the care and management of resident's needs including one resident with behaviour issues that did not have this fully documented in the care plan. This audit has identified that this is an area that still requires improvement.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care delivery is recorded by the nurse manager, enrolled nurses, or caregivers on every shift in the events notes section of the resident care computer programme. When a resident's condition alters, the RN initiates a review and if required a GP consultation or referral to the appropriate health professional. The three caregivers interviewed stated they have all equipment necessary to provide care. There is adequate protective apparel available - gloves, aprons and masks. Continence products were available and resident files included a urinary continence assessment, bowel management, and continence products identified and other management. Specialist continence advice is available as needed and this could be described. Continence education has been completed September 2014. Dressing supplies were available and a treatment room is well stocked for use. There are wound management plans in place for five residents with wounds. This was a previous audit finding that has now been addressed. Specialist wound

		<p>advice is available as needed confirmed by the nurse manager and enrolled nurse on duty. The service also has access to the medical centre situated close by and practice nurses are available for wound care treatment and advice if required. Wound care education has not been completed within the last two years (# link 1.2.7.5).</p> <p>Resident falls were recorded in the progress notes, reported to nurse manager on accident/incident forms, family notified, GP notified. Residents and families interviewed confirmed that care being provided was holistic and met the assessed needs of the residents.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	PA Low	<p>The Eden related philosophy of care is in place for the home and is incorporated in to the activity programme over five days per week 6/10 principles achieved). Cards and movies are programmed for Saturday and Sunday. A social and lifestyle profile is completed within 48 hours of new resident admission. An activity care plan was developed within three weeks of admission in three of five files reviewed (one resident is on respite care). Progress notes, evaluations and individual attendance records on activities were maintained. A resident forum is held weekly for informal feedback to management as well as a formal resident meeting held two monthly (9 December 2014). These meetings are held to provide residents with the opportunity to feedback on the programme and provide suggestions for activities, entertainment and outings. The DT, activities assistant and staff respect the resident's choice if they do not wish to participate in activities. The six residents interviewed were very satisfied with the activity programme and choice offered. Activities take place either in the home or in the purpose built recreation centre available to rest home and retirement village residents. The centre has a gym, an indoor swimming pool, auditorium, meeting room and a café. There are visiting groups such as school children's groups, and guest speakers. Residents are facilitated to attend their own church, friendship clubs and some residents attend the local men's shed. Spiritual needs and preferences are met. There are two chaplains on staff. Residents are also taken on holiday and day trips. There is one van for use for outings such as shopping trips, museum visits and other places and areas of interest. Other vehicles are hired as needed. D16.5d Four of five resident files reviewed identified that the individual activity plan is reviewed when at care plan review (one respite).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	FA	<p>Four of four long term care plans evaluations have been completed at least six monthly (one resident is on respite care). The family are invited to attend the multidisciplinary team (MDT) review. All four long term resident files sampled</p>

comprehensive and timely manner.		evidenced resident/family participation in the evaluation of the long term care plan. Short term care plans focus on acute and short term needs and were regularly evaluated, resolved or written into the long term care plan as an on-going problem. Short term care plans were in use for changes in health status including infections and wounds. Relatives interviewed confirmed they were notified of any care plan changes and outcome.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The service displays a current building warrant of fitness which expires on 1-Feb-2015.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	There are documented processes implemented and annual review of the infection control programme completed May 14. The infection control programme includes clear lines of accountability and is appropriate for the size, complexity, and degree of risk associated with the service. Surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. The nurse manager is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly. The nurse manager confirmed the service effectively managed a norovirus outbreak in 2014 that affected 33 residents and 18 staff. Public health was notified appropriately.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The restraint minimisation policy includes restraint/enabler procedures. There is a documented definition of restraint and enablers which is congruent with the definition in the standard. The policy was updated following feedback from the document review. Any assessment of use of enablers would be based on information in the care plan, discussions with residents and on staff observations of residents. The service remains restraint-free and no residents require enablers. The nurse manager states that any restraint is used only when absolutely necessary and after a last resort. Staff are trained in restraint minimisation and this involved a questionnaire April 2014.

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)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	An annual education plan which exceeds eight hours annually including compulsory a study day for all staff is in place.	Wound management education has not been provided in 2013 or 2014.	<p>Provide wound management study for clinical staff.</p> <p>60 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	On review of five resident assessments, the life plan computer assessment tool has been utilised for assessing pressure risk, falls risk, pain, continence, and mobility. InterRAI assessments had been completed for three of the five residents files reviewed. One resident had documented challenging behaviour and staff on interview were able to describe the challenging behaviour and how to manage the resident. Three residents had risk assessments reviewed six monthly and more frequently when required.	Two residents have not had risk assessments reviewed six monthly.	<p>Ensure that all residents have risk assessments reviewed at least six monthly.</p> <p>90 days</p>

<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Low</p>	<p>On review of four long term care plans one resident with behaviour issues relating verbal aggression does not have these issues fully documented in the plan, nor triggers for behaviours or sufficient information to guide staff in the de-escalation and management of behaviours.</p>	<p>One care plan reviewed did not reflect all the interventions and care requirements needed to guide staff in the care and management of behaviours that challenge.</p>	<p>Ensure that all care plans are individualised, and capture the current care requirements and interventions needed to guide staff in the care and management of residents.</p> <p>90 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>A social and lifestyle profile is completed within 48 hours of new resident admission. An activity care plan is developed within three weeks of admission.</p>	<p>One resident did not have an activity care plan developed until six months after permanent admission.</p>	<p>Ensure that all resident have an activity care plan developed within the required time frame.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.