

# Ilam Lifecare Limited

---

## Introduction

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

The audit has been conducted by Health 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:

<b>Legal entity:</b>	Ilam Lifecare Limited
<b>Premises audited:</b>	Ilam Lifecare
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 18 March 2015 End date: 18 March 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	79

# 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

Ilam Lifecare provides hospital (geriatric), rest home and dementia care for up to 121 residents. On the day of audit there were 79 residents. The service is managed by an experienced facility manager (registered nurse). The residents and relatives interviewed all 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 service has addressed all findings from the previous audit in relation to ensuring advanced directives are signed by the GP, results of resident and family surveys are reported, notification of outbreaks to reporting bodies in a timely manner, residents are seen by GP monthly unless assessed as being stable, aspects of medication, dating of decanted foods, calibration of medical equipment and carpet repairs.

This audit identified improvements required around complaints management, annual staff appraisals and aspects of care planning.

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

The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent and advanced directives completed. Complaints and concerns have been managed and 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.
---	--	---

The service is managed by an experienced aged care registered nurse supported by a clinical manager and registered nurses on duty 24/7.

The facility is guided by a comprehensive set of policies and procedures. An internal audit programme monitors service performance with corrective actions developed for any short-fall in service identified. Health and safety policies, systems and processes are implemented to manage risk. Adverse events were effectively managed. Human resources processes were

managed in accordance with good employment practice. The orientation and education and training programmes for the staff ensure staff are competent to provide care.

## 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.
--	--	---

Registered nurses are responsible for care plan development with input from residents and family. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met

## 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.
--	--	--

Ilam Lifecare has a current building warrant of fitness that expires 1 September 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 documented definition of restraint and enablers that aligned with the definition in the standards. On day of audit there were six residents utilising restraint and no use of enablers. The service includes education and discussion on restraint and enabler practices.

## 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 infection control co-ordinator reports surveillance data and infection control matters to meetings where analysis and trends is discussed. All staff receive infection control education on orientation and annually. Infection control audits are included in the annual audit schedule.

## 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)
<b>Standards</b>	0	13	0	4	0	0	0
<b>Criteria</b>	0	38	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Advanced directives were recorded as evidenced in the six resident files reviewed (two hospital, two rest home and two dementia) and these were signed by the GP. This was a previous audit finding that has now been addressed.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	PA Low	<p>There is a complaint register maintained with all complaints investigated and improvements identified and implemented where able. The information pack includes information on the complaint process and residents and family interviewed demonstrated an understanding and awareness of these processes. Improvement is required to ensure complainant response to outcome is documented and resolution confirmed.</p>

understood, respected, and upheld.		
<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>Residents' files reviewed document communication with family. There was communication with the GP and family following adverse events, which was recorded on the accident/incident forms and resident progress notes. G.P., residents (five rest home and two hospital) and family (two rest home, one hospital and one dementia) interviewed confirmed that staff communicate well with them. Resident family meetings are conducted four times a year with meeting minutes sighted.</p> <p>The service has policy and procedure that guides access to interpreter services if required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Ilam Lifecare is certified to provide rest home, hospital and dementia level care in dedicated purpose built wings for up to 121 residents. The service can also provide rest home level care across 45 of the serviced apartment and studio units.</p> <p>On the day of the audit the facility occupancy was 79 residents including 21 rest home residents of 22 beds, 34 hospital residents in 34 beds, 19 residents in the 20 bed dementia units. There were five residents assessed as rest home level care in the serviced apartments.</p> <p>Ilam Lifecare is owned by a consortium of shareholders that recently joined the Arvida Group. As a result the service now has a regional co-ordinator and head office system to support the facility manager. The facility manager is an experienced aged care manager and registered nurse who has held the position for three years. The facility manager has completed relevant training of over eight hours in the last 12 months. The facility manager is supported by a clinical manager who has been employed at the service for 10 years.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	FA	<p>The service has a quality and risk management plan which has been reviewed for 2015 with key performance indicators that are discussed and progress monitored at the monthly combined health and safety and quality meeting. There is an internal audit schedule and internal audits are completed monthly by the quality manager with a corrective action plan completed where there are shortfalls identified. The health and safety and quality meetings occur monthly and discussion is held around staff and resident incidents/accidents, hazards, training, audits, staffing reports, complaints, policy and procedures, corrective actions, survey results and maintenance. A restraint and infection control meeting is also held monthly as evidenced by minutes sighted to discuss restraint use, performance against key performance indicators, infection rates, trends, evaluation, audits, prevention and outbreak</p>

<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>management.</p> <p>Each unit and section of staff such as registered nurses, housekeepers and diversional staff hold staff meetings with discussion around infection control, housekeeping, general business, education, laundry, meals, resident's cares, and communication. Minutes for 2014 were sighted with these available to staff. Twice a year a combined staff meeting is held to welcome new staff and to discuss complaints, compliments and matters relating to all staff. Minutes include actions to achieve compliance where relevant.</p> <p>Corrective actions are developed following audits, meetings, complaints, hazard identification, feedback from staff, survey results and incidents and accidents to ensure tracked improvements and preventative measures are identified. This, together with staff training, demonstrates Ilam Lifecare's commitment to on-going quality improvement. Discussions staff who work across the facility confirmed their involvement in the quality programme.</p> <p>Resident/relative meetings take place three monthly in each unit. An annual resident satisfaction survey was conducted and comments of interpreted as complaints added to the complaints register for action. The outcomes of the 2014 surveys were communicated in the resident and family newsletter which meets the previous finding.</p> <p>An annual analysis for 2014 data was sighted which included measurement of key performance indicators and corrective actions completed.</p> <p>A quality project to improve the call bell system and staff response times was documented and reported in meeting minutes as improving response times. Falls prevention strategies are implemented for individual residents.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>During interview staff demonstrated an understanding of the incident accident reporting requirements and that they document adverse, unplanned or untoward events on an incident/accident form, which is then forwarded to management. These reports are investigated with improvement actions identified and completed as evidenced in resident files and the health and safety and quality meeting minutes.</p> <p>Staff and management confirm during interviews, that they are aware of their essential notification responsibilities through job descriptions; policies and procedures; and professional codes of conduct.</p> <p>Monthly accident/incident analysis forms and an annual analysis of data for 2014 along with incident forms for January and February 2015 were sighted. The data includes date, time, and name of residents, accident type / location, injury and treatment required. Neurological observations were sighted for resident's falls that may contribute to a head injury.</p> <p>The service had two infectious outbreaks in 2014 that were reported to Public Health as evidenced by documentation sighted. This previous finding is resolved.</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>	<p>PA Low</p>	<p>The skills and knowledge required for each position within the service is documented in job descriptions. Staff files (six of six) evidenced all required employment documentation. Individual records of education were maintained for each staff member.</p> <p>An orientation programme including core requirements and relevant to the staff member's job description is completed by all new staff with records sighted on six of six staff files confirming completion.</p> <p>In-service registers for 2014 documented education provided at the facility which included a comprehensive range of training for the three levels of care provided. Staff are supported to complete an aged care education programme with a dedicated aged care programme trainer, a register was sighted identifying that all caregiver staff have completed or have commenced training. Interview with staff confirmed a range of education was provided in a variety of formats two to three times per month. All caregivers who have worked in the dementia unit more than six months have completed the required dementia units.</p> <p>Registered nurses are supported to complete external training such as palliative care and wound management.</p> <p>A copy of practising certificates is maintained.</p> <p>Improvement is required to ensure all staff have a performance appraisal completed at least annually.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining service provider levels and skill mixes in order to provide safe service delivery the residents in the three levels of care hospital, dementia and rest home. There is a minimum of one registered nurse on duty 24/7 in the hospital level care with dedicated registered nurse cover in the dementia and rest home. The clinical manager and facility manager who is a registered nurse also provide support to the registered nurses. Care staff interviewed report that there was enough staff on duty and they were able to get through the work allocated to them including replacing staff when not available with available staff or agency staff.</p> <p>The dementia unit has dedicated caregiver staff who remain in the unit.</p> <p>Residents and family interviewed report there is enough staff on duty to provide adequate care.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with</p>	<p>FA</p>	<p>The service uses individualised medication blister packs which are checked in on delivery. Two registered nurses and a medication competent caregiver were observed administering medications correctly. Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements. This was a previous audit finding that has now been addressed. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all 12 medication charts reviewed. An annual medication administration competency was completed for all staff administering medications and medication training had been conducted.</p>

<p>current legislative requirements and safe practice guidelines.</p>		<p>There is a self-medicating resident's policy and procedures in place. There was currently one resident who self-administered medications with competency completed. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. All 12 medication charts reviewed recorded indication for use of as required medication by the GP. PRN (as required) medication is reviewed by a registered nurse, prior to administration. Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed.</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>	<p>FA</p>	<p>All meals at Ilam Lifecare are prepared and cooked on site. There is a four weekly winter and summer menu which had been reviewed by a dietitian. The main meal of the day is served in the evening and a lighter lunch is provided. Meals are prepared in a well equipped kitchen and served to residents from a bain marie in each area. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. All decanted food was dated which was a previous audit finding that has now been addressed. Staff were observed assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurse or nurse manager. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. There are snacks available 24 hours.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Care plans are current and interventions reflect the assessments conducted and the identified requirements of the residents in five of six files reviewed. Interviews with staff (clinical manager, registered nurses, caregivers) and relatives confirmed involvement of families in the care planning process. Dressing supplies are available and a treatment room was stocked for use. Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Wound assessment and wound management plans were in place with assessment, treatment and evaluation completed. Referral to wound specialist was activated for complex wounds.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>FA</p>	<p>The activities staff provided an activities programme over five days each week. The diversional therapist oversees the activities programme. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned for the day are displayed on notice boards around the facility. A diversional therapy plan is developed for each individual resident based on assessed needs. Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed. Consideration has been taken to provide meaningful activities that can cover 24 hours in the dementia unit, which are implemented by caregivers and activity</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>staff. Caregivers working in the dementia unit are orientated to activities. Volunteers assist at the weekends. Residents are encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. The service has a van that is used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed were updated as changes were noted in care requirements (# link 1.3.6.1). Care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short term care plans are utilised for residents and any changes to the long term care plan were dated and signed. Care plans are evaluated within the required time frames.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Ilam Lifecare has a current building warrant of fitness that expires 1 September 2015.</p> <p>The previous audit identified that not all medical equipment and hoists in use had been checked/calibrated. An external company was engaged to complete this requirement 27 November 2013 and 21 October 2014. The weigh scales were separately calibrated 17 September 2013. This previous shortfall has now been addressed.</p> <p>A tour of the facility identified that new carpet had been laid in the hospital lounge and hallway and in other hallway areas with no trip hazards identified. This previous finding has now been addressed. The facility manager described an ongoing plan to replace older carpet areas.</p>
<p>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</p>	<p>FA</p>	<p>At interview the clinical manager, who is the infection control co-ordinator, presented documented evidence of surveillance both individual recording of infections and a register which is collated monthly and presented at the infection control committee meeting for discussion and trending. Monthly infection data is collected for all infections based on signs and symptoms of infection.</p> <p>Staff training had been completed July 2014 to ensure staff understanding of the surveillance requirements for residents.</p>

control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. Documented systems are in place to ensure voluntary use of enablers with assessment, care planning, evaluation and monitoring requirements. Currently there are no residents using enablers. Six restraints were in use and documentation reviewed confirmed all requirements were met.</p> <p>Staff training was completed March 2014 using a self-directed learning tool.</p> <p>A 2014 annual analysis was sighted which reviewed restraint and enabler use.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	An up to date complaints register is maintained. The facility had received four complaints during 2014 and to date in 2015. Also 17 comments contained in the October survey's and two comments from residents meetings interpreted as complaints were transferred to the complaint system and processed to identify possible improvements – all were treated as anonymous.	Of the four complaints received by individual complainants two of four did not include documentation that the complainant accepted the outcome and the complaint is resolved.	Ensure complainant response to outcome is documented and resolution confirmed.  90 days
Criterion 1.2.7.5 A system to	PA Low	On interview the Facility Manager described an annual performance appraisal system. The service internal audit processes had identified that not all staff had had an appraisal	Three of five staff files for staff employed over 12 months reviewed did not have a	Ensure all staff have a performance

identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.		completed within the last 12 months and a corrective action plan had been developed. RN and medication competent staff have an annual competency review for (but not limited to) medication, wound care, use of movement equipment, which was sighted for four staff. The facility manager stated that some staff were not engaging in the process by completing the employee section of the tool commence the appraisal being completed.	performance appraisal completed annually.	appraisal completed at least annually  90 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 nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy. Assessments are completed including falls risk, continence, pain and pressure area risk. The InterRAI tool is being used.	There was no evidence of nutritional assessments completed. Dietary profiles are completed and reviewed six monthly. The service records monthly body mass index for each resident.	Ensure that all residents have nutritional assessments completed and these are reviewed with identified weight changes.  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 nurses are responsible for undertaking the assessments on admission. Risk assessments include falls risk, continence, pressure area risk and pain. A dietary profile is completed. The service records monthly body mass index for each residents. All assessments are reviewed six monthly or more frequently when required.	One resident in the dementia unit had noted weight loss with no updated intervention in the care plan to support weight management. Body mass index had been recorded monthly and was still within normal range. The resident's family was aware of the weight loss. Staff including the chef were aware of the resident's weight loss.	Ensure the residents care plan documents interventions to support all identified needs and direct staff in resident care.

				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, 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.