

# Diana Isaac Retirement Village Limited

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## 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>	Diana Isaac Retirement Village Limited
<b>Premises audited:</b>	Diana Isaac Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 16 March 2015 End date: 17 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>	126

# Executive summary of the audit

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## 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

Diana Isaac Retirement Village is a Ryman Healthcare facility, situated in Christchurch. The service provides rest home, hospital and dementia level care. On the days of audit there were 39 rest home residents, 39 hospital residents and 39 residents across the two dementia units. Nine rest home residents also reside in the serviced apartments. The village manager has been in role for six months and is an experienced manager. She is supported by two clinical managers (registered nurses) who oversees the care centre, and a regional manager.

This unannounced surveillance audit was conducted to assess the facility against a subset of the health and disability service standards and the DHB contract. There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme. Feedback from residents and families was very positive about the care and services provided.

The service has addressed two of two previous findings relating to implementing quality improvements and the use of short term care plans.

## 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 and documented. 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.		Standards applicable to this service fully attained.
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Diana Isaac continues to implement the Ryman Accreditation Programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Diana Isaac provides clinical indicator data for the three services being provided (hospital, rest home and dementia). The service has addressed a previous finding relating to developing quality improvements from internal audits. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

## 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.

Standards applicable to this service fully attained.

Initial assessments and risk assessment tools are completed by the registered nurses on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe. Monitoring forms are available and utilised. Care plans demonstrate service integration, are individualised and evaluated six monthly. The resident/family/whanau interviewed confirmed they are involved in the care plan process and review. Short term care plans are in use for changes in health status. The service has addressed this previous finding. Interventions are documented to reflect the resident's current needs. The activity coordinators provide an activities programme in each unit that meets the abilities and recreational needs of the residents that is varied, interesting and involves the families and community. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. Medication is appropriately stored, managed, administered and documented. Meals are prepared on site. The menu is designed by a dietitian at organisational level. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

## 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 displays a current building warrant of fitness.

## 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.
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There are comprehensive policies and procedures that meet the restraint standards. There is a restraints officer (clinical manager) with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes. Restraint use is discussed at RN, staff and management meetings. There is restraint education at orientation and ongoing. There are two hospital residents with restraints in use and one hospital resident with an enabler.

## 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.
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The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities.

## 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	17	0	0	0	0	0
<b>Criteria</b>	0	40	0	0	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and supporting documents are being implemented. The village manager has the overall responsibility for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A feedback form has been completed for each complaint recorded on the complaint register. The number of complaints received each month is reported to staff via the various meetings. A complaints register has been maintained that includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Verbal complaints are included and actions and response are documented. Discussion with residents and relatives confirm they were provided with information on the complaints process. Complaints information is provided on admission.</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>There is an incident reporting policy, and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. The incident forms have a section to indicate if family have been informed (or not) of an accident/incident. A sample of incident forms reviewed for February 2015 identified that family were notified following a resident incident. Interpreter policy and contact details of interpreters are available. Non-Subsidised residents are advised in writing</p>



		<p>of their eligibility and the process to become a subsidised resident should they wish to do so. Relatives interviewed (four hospital and two dementia) stated that they are informed when their family members health status changes. The information pack is available in large print and this can be read to residents. The information pack and admission agreement included payment for items not included in the services. A specific introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility.</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>Diana Isaac provides care within a three level facility. On the days of audit there were 39 residents in the rest home unit (dual purpose) – 38 rest home including one respite and one hospital level resident. In the hospital unit there were 38 residents, and in the dementia units there were 39 residents. Nine rest home level residents reside in the serviced apartment's area. There is a documented ' purpose, values, scope, direction &amp; goals policy. Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation wide objectives are translated at each Ryman service. Ryman Healthcare have operations team objectives 2015 that include a number of interventions/actions. Each service also has their own specific Ryman accreditation programme objectives and progress towards objectives is updated as part of the RAP schedule. The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and dementia care.</p> <p>The village manager at Diana Isaac is non clinical and has been in the post for six months. She is supported by two clinical managers. The village manager has completed a comprehensive orientation to the role and has attended a two day managers training day. The management team is supported by the Ryman management team including a regional manager who was present on the days of audit.</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</p>	FA	<p>Diana Isaac continues to implement the Ryman accreditation programme (RAP) system. Quality and risk performance is reported across the various meetings including (but not limited to) RAP committee, full facility, registered nurse and caregivers. Issues are also reported through the weekly management meetings and a weekly report is provided to the regional manager.</p>

<p>principles.</p>		<p>The service has policies and procedures and the RAP programme defines systems to provide an 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. Policy and procedure review is coordinated by head office, with facility staff having the opportunity to provide feedback (staff interview). Facility staff are informed of changes/updates to policy at the various staff meetings.</p> <p>Key components of the quality management system link to the RAP committee at Diana Isaac who meet monthly. Weekly reports by the village manager to the regional manager and quality indicator reports to that are sent to head office (Christchurch) provide a coordinated process between service level and organisation. There are monthly accident/incident reports completed by the clinical manager collected across rest home, dementia and hospital services as well as staff incidents/accidents. The service has linked the complaints process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. The Diana Isaac health and safety and infection control committees meet bimonthly and include discussion of incidents/accidents and infections. Infection control is also included as part of benchmarking across the organisation.</p> <p>Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified. The service has addressed and monitored this previous finding. QIP's reviewed are seen to have been closed out once resolved. Resident and relative surveys have been conducted with corrective actions developed and implemented as a result of the feedback.</p> <p>There is a comprehensive health and safety and risk management programme in place. There are policies to guide practice. Diana Isaac has a health and safety representative who has completed training.</p> <p>Fall prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Ryman (including Diana Isaac) has introduced a fluid assistant/lounge caregiver position. This was introduced for two reasons: a) in response to relative feedback that indicated residents were unsupervised in lounge areas and b) in an attempt to reduce clinical indicator rates (e.g. falls).</p>
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<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>Incident and accident data is collected and analysed and benchmarked through the Ryman benchmarking programme. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for February 2015 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. Incidents and accident data is communicated to staff, as evidenced in meeting minutes reviewed and staff interviews. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</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>FA</p>	<p>The organisation provides documented job descriptions for all positions which detail each position's responsibilities, accountabilities and authorities. Relevant documentation was seen in eight staff files reviewed. Health practitioners and competencies policy outlines the requirements for validating professional competencies. A register of practising certificates is maintained. There is a 2015 training plan developed for Diana Isaac that is aligned with the RAP. There is an enrolled nurse who oversees staff induction and the ACE programme, and a clinical manager who facilitates the in-service calendar. Participation in the ACE programme is a requirement for caregivers. Ryman ensures RNs are supported to maintain their professional competency. There is an RN journal club that is required to meet two monthly at all Ryman facilities and subjects covered include (but not limited to) nutrition and weight loss, and communication. Training requirements are directed by Ryman head office and reviewed as part of the RAP reporting. There are a list of topics that must be completed at least two yearly and this is reported on. The clinical structure in the facility includes two clinical managers, registered nurse coordinators in the hospital, rest home and dementia units and a team of registered nurses and care staff.</p> <p>There are currently 17 caregivers employed in the dementia unit. Nine have completed dementia standards. Eight caregivers are working towards the completion of these unit standards. All eight staff have commenced employment in the dementia unit in the past six months.</p> <p>Ryman provide a comprehensive induction programme at Foundations Level 2 compliance and qualification to all care staff and actively support the Health Ed Trust ACE Programmes and provide incentives to their staff to undertake both the general and dementia modules. Completion of induction programme and required ACE</p>

		dementia standards are required to be monitored and reported monthly to head office as part of the RAP programme.
<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	<p>There is Ryman policy which supports the requirements of skill mix, staffing ratios and rostering. There is an RN and first aid trained member of staff on every shift. Caregiver's found that RN's (including coordinators) are supportive and approachable. Staff advise that there are sufficient staff on duty at all times. Interviews with residents and relatives confirm that there is sufficient staff rostered on. Staff and management inform there is capacity to increase staff numbers based on resident acuity, and there is access to both casual staff and part-time staff to cover unexpected absence.</p> <p>There are at least two RN's on duty in the care centre during the day. The caregivers cover a mix of long and short shifts. There are designated cleaners, laundry staff, activities staff, gardeners, and administration staff. The clinical managers work 40 hours per week and oversee the clinical care of all residents. The village manager also works 40 hours per week.</p>
<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 have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration (observed during medication rounds). A contracted pharmacy supplies packed medications. Medications are managed appropriately in line with required guidelines and legislation. Sixteen medication charts sampled met all the prescribing requirements. Each drug chart has a photo identification of the resident. Allergies or nil known allergies were recorded on the medication chart. Residents who wish to self-medicate are appropriately assessed and supported to do so. Internal medication audits are conducted six monthly. Medication charts reviewed identified that the GP had seen the reviewed the resident three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>There is a company hotel services manager. Kitchen staff includes cooks and kitchen hands. There is a four weekly seasonal menu that has been designed and</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>reviewed by a dietitian at organisational level. The kitchen staff receive information about each resident's dietary profile. Special and modified diets are catered for. Nutritious snacks such as desserts, yoghurt, custard, biscuits and sandwiches are available over 24 hours for residents in the dementia unit. Staff are observed sitting with the resident when assisting them with meals.</p> <p>The service has a large workable kitchen and the food service is managed in line with acceptable food safety practices. Staff have been trained in safe food handling with a refresher provided in May 2014. There is a cleaning schedule in place (sighted) which is signed off as duties are completed. Staff were observed wearing aprons, hats and gloves. Feedback on the service is received from resident and staff meetings, surveys and audits.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Previous certification audit identified that short term care plans were not utilised for all short term care needs. On review of the sample of resident files, there is evidence that short term care plans have been and continue to be used for short term care issues including infections, wound care, and changes in health status. The service has evidenced that they have addressed and monitored this previous finding.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>A written record of each resident's progress is documented. Changes are followed up a registered nurse (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and a treatment rooms are well stocked for use. Wound documentation was reviewed and included wound assessment, treatment plans and evaluations and progress notes for all wounds. Wound care nurse specialist advice is readily available. Continence products are available and specialist continence advice is available as needed. Short term care plans with interventions and on-going evaluations by the RN were evidenced. A physiotherapist referral is initiated if required and assessment of any equipment needed.</p>

<p><b>Standard 1.3.7: Planned Activities</b></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>	<p>FA</p>	<p>There are activity coordinators at Ryman Diana Isaac who provide a separate activity programme for the rest home, hospital, dementia unit and serviced apartments. The activities programme is provided for seven days a week in the facility by a combination of full time, part time and casual staff. Residents in the village apartments are involved in the activities programme. There are set calendar events and expectations for each area including the triple A exercise programme which is applicable to the cognitive and physical abilities of the resident group. The Engage at Ryman programme is being included in the programme and participation has increased since its commencement, the programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility.</p> <p>The resident is assessed on admission, and with family involvement if applicable. Likes, dislikes, hobbies, and past interests are discussed. A plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that includes an activities assessment, 'your life experiences', next of kin input into care and an activities plan. The plan includes categories for comfort and wellbeing, outings, interests and family and community links. One on one time is spent with residents who choose not to participate or who choose not to join in group activities.</p> <p>Residents are encouraged to maintain links with the community and there are regular outings and scenic drives for residents in all units. The service has a van which is utilised for outings. Activities in the dementia unit are individualised and based on sensory activities and normal daily activities. Resident meetings and surveys provide feedback on the activities programme. All residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The evaluation and care plan review policy require that care plans are reviewed six monthly. The written evaluation template describes progress against every goal and need identified in the care plan (sited in resident files). Short term care plans are utilised in the rest home, hospital, and dementia unit. Short term care plans are evaluated regularly and resolved or added to the long term care plan if an ongoing problem. Any changes to the long term care plan are dated and signed. Family are invited to attend the multidisciplinary review meetings (correspondence noted in files</p>

		reviewed). Resident medications and medical status are reviewed at least three monthly by the general practitioners.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness which expires on 1 August 2015.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Definitions of infections are in place appropriate to the complexity of service provided. Systems in place are appropriate to the size and complexity of the facility. An outbreak in December 2014 was appropriately reported and managed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Documented systems are in place to ensure the use of restraint is actively minimized. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The quality team reviews restraint use, education and audits. The service currently has two hospital residents who have been assessed as requiring the use of a restraint (bedrails and/or chair belt) and one hospital resident with an enabler (lap belt). There are no rest home or dementia residents with restraint or enablers. All restraint/enablers are utilised as a falls prevention measure. A monthly restraint and enabler register is maintained. The long term care plan (under safety/risk) includes the use of restraint/enablers, frequency of monitoring and required documentation. There are restraint monitoring guidelines in place. All documentation was completed including authorisation, consent, planning, monitoring and review for the files reviewed.

## Specific results for criterion where corrective actions are required

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

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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
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End of the report.