# Alpine Retirement Group Limited - Alpine View Care Centre & Alpine View Lodge

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Alpine Retirement Group Limited

**Premises audited:** Alpine View Care Centre||Alpine View Lodge

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

**Dates of audit:** Start date: 2 November 2016 End date: 3 November 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 48

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

The Alpine View care centre provides rest home and hospital level of care for up to 47 residents. On the day of audit, there were 46 residents, (41 rest home and five hospital level care). Alpine View retirement village (the Lodge) is a separate complex with 40 one bedroom serviced apartments that have been certified to provide rest home level of care. On the day of audit, there were two rest home residents in the serviced apartments. The serviced apartments have staff on duty 24 hours.

The care centre is managed by a nurse manager. She is supported by a clinical director who oversees the clinical governance of the company. The clinical director and nurse manager both report to the chief executive officer (CEO).

This surveillance audit was conducted against aspects of the 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, interviews with residents, family, management, staff and a general practitioner.

The service has addressed all of the findings from the partial provisional audit around transcribing of medications, the purchase of showering equipment, completion of a wet room which could accommodate a shower trolley and the provision of ramps to allow for wheel chair access from communal areas to the garden.

The service has addressed the previous certification audit findings around the completion of advance directives, complaints follow-up, reporting of quality outcomes to staff, and infection control training for the coordinator.

This audit has identified that improvements are required around the completion of staff annual performance appraisals and short-term care plans.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Communication with residents and families is appropriately managed and recorded. Complaints are managed and residents and families are aware of the complaints process.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Alpine View care centre is managed by an experienced nurse manager. The nurse manager is supported by a clinical director, registered nurses and care staff.

Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope and strategic direction. The strategic plan has goals documented. There are policies and procedures to provide appropriate support and care to residents with rest home, hospital and dementia level needs and a documented quality and risk management programme that is implemented.

Staff receive ongoing training and there is a training plan being implemented for 2016. Rosters and interviews indicate that there are sufficient staff who are appropriately skilled.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

Assessments, care plans and reviews are completed by a registered nurse within the required timeframes. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents and relatives interviewed were complimentary about the food service.

## Safe and appropriate environment

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

The building holds a current warrant of fitness.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Alpine View care centre has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. There were no residents requiring the use of restraints or enablers.

## Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. 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.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 17 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 2 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. Residents and relatives interviewed confirmed they have been made aware of and fully understand informed consent processes and confirmed that appropriate information had been provided.Advance directives, if known, were on the residents’ files. Resuscitation plans for competent residents were appropriately signed. One hospital resident was deemed incompetent to make an informed decision; the GP had documented this and had documented that resuscitation was not clinically indicated due to the resident’s current medical conditions. This finding from the previous certification audit has been addressed. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints policy and procedures are being implemented, and residents and their family/whānau are provided with information on admission.The complaints policy is posted in a visible area with complaints forms and advocacy information nearby. The residents and families interviewed were aware of the complaints process and to whom they should direct complaints. There is a complaint register that includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented. The previous audit finding has been addressed. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Four relatives interviewed (two rest home and two hospital) stated they are informed of changes in health status and incidents/accidents. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. A sample of twelve incident forms reviewed from September to October 2016 identify family were notified following a resident incident. Interview with staff confirms that family are appropriately notified following a resident change in health status. Six residents interviewed (four rest home and two hospital) also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Alpine View retirement village Board of Directors and clinical director provide governance (including clinical governance) and support to the nurse manager at the care centre. The chief executive is also a director. The service is managed by an experienced nurse manager. Alpine View care centre is certified to provide rest home and hospital level care for up to 47 residents at the care centre and up to 40 residents at rest home level within the serviced apartments (separate complex). On the day of audit, there were 46 residents in the care centre (41 rest home residents including two respite, and five hospital residents receiving hospital level care). There were two residents in the serviced apartments assessed as rest home level care. The nurse manager has completed eight hours of professional development related to managing a rest home and hospital facility. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality manual and the strategic, business, quality, risk and management planning procedure describe the quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the weekly head of department meetings, six weekly management meetings, monthly staff meetings and monthly health and safety meetings. All meetings have been held as per the meeting schedule. This finding from the certification audit has been addressed. Monthly and annual reviews have been completed for all areas of service. Meeting minutes have been maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with registered nurses and health care assistants confirmed their involvement in the quality programme. Resident/relative meetings have been held.Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2016 is being completed. Areas of non-compliance identified at audits have been actioned for improvement. Specific quality improvements have been identified and benchmarking with other facilities occurs on data collected. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies are implemented for individual residents. Residents’ are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. A sample of 12 resident incident and accident reports for September-October 2016 were reviewed. All reports were complete and evidenced timely clinical review of the resident with further investigations and analysis conducted as required. Pressure injuries have been reported. Accidents and incidents are analysed monthly with results discussed at combined two monthly infection control/quality meetings. The nurse manager is aware of situations that require statutory reporting. Appropriate authorities were informed of a recent outbreak. The service has completed two section 31 notifications to the Ministry of Health in 2016. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low | Seven staff files were sampled (two registered nurses (RNs), one enrolled nurse (EN), two healthcare assistants, one cook and one activities coordinator). All files reviewed contained documentation relating to evidence reference checking, completion of an orientation programme and job descriptions. Annual appraisals were not evidenced to be completed for all staff who had been employed for more than twelve months. Current annual practicing certificates are kept on file.There is a fully implemented and comprehensive training plan in place. All education had been delivered as per the training plan. There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to) medication management and syringe driver training and competencies. Senior healthcare assistants also complete medication training and competencies. Residents and families state that staff are knowledgeable and skilled. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for staffing the service. Staffing rosters were sighted and staff are on duty to match the needs of different shifts and needs of different individual residents. Registered nursing cover is provided 24 hours a day, seven days a week. Sufficient numbers of healthcare assistants support RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory. There is a registered nurse on duty Monday - Friday 9am - 5pm in the Lodge. Healthcare assistants are rostered on duty 24/7 in the Lodge. The registered nurses and nurse manager provide afterhours on call support. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policies and procedures comply with medication legislation and guidelines. The service uses an electronic medication management system. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed, is signed for correctly for the sample of 12 medication charts reviewed (seven rest home, including one respite resident and one rest home serviced apartment resident, and five hospital). Registered nurses, enrolled nurses and healthcare assistants administer medications. Staff who administer medication have been assessed as competent. The facility uses a blister pack medication management system for the packaging of all tablets. The RNs reconcile the delivery and this is documented. Medication charts (electronic) are written by medical practitioners and there was evidence of three monthly reviews by the GP. Medications are prescribed and charted in line with guidelines including indications for use for as needed medications. There was no evidence of transcribing found in the care plans sampled. The finding from the partial provisional audit has been addressed. There were three rest home residents self-administering medicines. Competency assessments to self-administer medications are in place and review three monthly by the GP. Secure storage was observed with each resident having a lockable drawer in their room. Standing orders were not in use.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food service at Alpine View care centre and Lodge is provided by trained staff in well-appointed kitchens. The kitchen is centrally located adjacent to the main dining room in the care centre. The kitchen in the serviced apartment area is located beside the restaurant. The catering manager is based at the Lodge. A tray service is provided to residents who are unable to attend the dining room. Food service manuals are in place to guide staff. A resident dietary profile is developed for each resident on admission and is provided to the kitchen staff. The kitchen is able to meet the needs of residents who require special diets and the cooks work closely with the registered nurses. Kitchen staff have completed food safety training. The cooks follow a rotating menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are routinely monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Healthcare assistants follow the care plans and report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral. Staff have access to sufficient medical supplies including dressings. Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Monitoring forms are in place for restraint use, behaviour management, fluid balance charts, turning charts and pain management. Wound documentation is available and includes assessments, management plans, progress and evaluations. There were two hospital residents with a wound, one resident with removal of a lesion and one resident with a skin tear. There was one rest home resident with a stage-1 pressure injury. The RNs have attended wound care training. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities coordinator is a qualified diversional therapist who works Monday - Friday. Each resident has an individual activities assessment on admission and from this information, an individual diversional therapy plan has been developed by the activities staff for the resident files sampled. The activities programme reflects the residents’ cognitive and physical abilities. The activities programme includes scheduled time for one-on-one activities with residents who prefer not to join in group activities or are unable to join in activities. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. Residents and families interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan is reviewed at least six monthly or earlier if there is a change in health status. Reviews document progress toward goals. There is at least a three monthly review by the GP. Changes in health status are documented and followed up. Care plan reviews are signed by an RN. Short-term care plans are utilised for acute changes in residents’ condition. However, not all short-term care plans reviewed were signed off when resolved. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Reactive maintenance and a planned maintenance schedule is in place that has been maintained. There is a full-time maintenance person employed who has completed health and safety training.Records reviewed evidenced all electrical equipment had been tested and all medical equipment had been calibrated and checked, this included all hoists. A reclining shower chair has been purchased, (sighted). This previous finding identified at provisional audit has been addressed. The healthcare assistants and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care.The hot water temperatures are monitored weekly and maintained between 43-45 degrees Celsius. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained. There is outdoor furniture and shaded areas. There is wheelchair access to all areas. This finding at the previous provisional audit has been addressed. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All rooms have ensuite facilities. There are adequate numbers of communal toilets located near the communal areas. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Residents interviewed reported their privacy is maintained at all times. There is a large “wet room” sighted which is spacious and can accommodate the use of a shower trolley or large recliner shower chair. This finding from the provisional audit has been addressed. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse is the designated infection control (IC) nurse. The IC nurse has attended external IC training in 2016. The service has addressed this previous finding. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff through the staff/quality meeting) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme. A registered nurse is the infection control coordinator. 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 onto a monthly infection summary. This data is monitored and evaluated monthly and annually and is benchmarked with other facilities. Outcomes and actions are discussed at infection control meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse manager. Since the previous audit, there has been one recent outbreak which was well contained. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service has documented systems in place to ensure the safe and appropriate use of restraint. Policies and procedures include the definition of restraint and enabler that are congruent with the definitions in NZS 8134.0. There were no residents requiring the use of a restraint or enabler. Staff education on RMSP/enablers has been provided.  |

# 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 1.2.7.3The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Documentation relating to evidence reference checking, completion of an orientation programme and job descriptions was evident in all the files reviewed. An annual appraisal was evidenced to be completed in one staff file. | Two of three staff files reviewed for staff who have been employed for over twelve months did not have an annual appraisal completed. | Ensure annual staff appraisals are completed for all staff who have been employed for over twelve months.90 days |
| Criterion 1.3.8.3Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Low | Short-term care plans were evidenced in use in the sample of resident files reviewed. Not all short-term care plans had been signed off when resolved. | In three of six resident files reviewed, short-term care plans had not been signed off by a registered nurse when resolved or transferred into the long-term care plan. | Ensure short-term care plans are signed off by a registered nurse when resolved or transferred into the long-term care plan.90 days |

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

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

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

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

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| No data to display |

End of the report.