

Royal Heights Care Limited - Royal Heights Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Royal Heights Care Limited
Premises audited:	Royal Heights Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 September 2018 End date: 13 September 2018
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:	43

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

Royal Heights Rest Home provides rest home level care for up to 45 residents. The service is privately operated and managed by a general manager who oversees all service provision and a nurse manager who holds a current nursing practising certificate. The nurse manager is supported by a quality assurance manager. There have been no changes to the service or facilities since the previous audit. Residents and the family member interviewed spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner.

This audit identified no areas for improvement. There were no areas identified as requiring improvement at the previous audit.

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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Open communication between staff, residents and families is promoted and confirmed to be effective. The service has access to the district health board translation and interpretation service.

A complaints register is maintained with complaints resolved promptly and effectively.

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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. Experienced and suitably qualified people manage the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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.
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The registered nurse and the general practitioner assess residents' needs on admission. Lifestyle care plans are individualised based on a comprehensive range of information and accommodate any new problem that might arise. Short term care plans are developed and implemented as needed. Residents' records sighted demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as and when required.

The planned activity programme provides residents with a variety of individual and group activities and residents are encouraged to maintain their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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.
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There is 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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The organisation has implemented policies and procedures that support a restraint free environment. No enablers or restraints were in use at the time of audit. Policy contains a comprehensive assessment, approval and monitoring process should restraint be implemented. Policy identifies that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes and annual education is undertaken.

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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Staff demonstrated good principles and practice around infection control which is guided by relevant policies and supported with regular education. Aged care surveillance is undertaken, and results are reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	39	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Forms are displayed and available beside the residents' notice board.</p> <p>The complaints register reviewed showed that nine complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes required. Action plans showed any required follow up and improvements have been made where possible. The nurse manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/relatives health status and were advised in a timely manner about any incidents or accidents. This was supported in the residents' records reviewed. Staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code.</p>

<p>provide an environment conducive to effective communication.</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>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly and annual quality review reports which are sent to the general manager who then reports to the owner/directors, showed adequate information to monitor performance is reported including financial performance, quality data results and outcomes, staffing, education, emerging risks and issues. The nurse manager and quality assurance manager stated there is excellent communication between owner/directors and management. The general manager visits the facility at least twice a week and the owner/directors also visit the facility regularly.</p> <p>The overall service is managed by a general manager who has been involved in the business since 1992 and the nurse manager is responsible for day to day clinical care of residents. She has been in the role since 1997 and holds a current annual practising certificate as a registered nurse. The quality assurance manager has worked at the facility since 2003 and in her current role since 2009. All members of the management team hold relevant qualifications. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Members of the management team confirmed their knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing education and training both on and off-site.</p> <p>The service holds contracts with Waitemata District Health Board for rest home level care which include respite care and chronic health conditions. All 43 residents receiving care at the time of the audit were receiving services under the Age Related Residential Care contract.</p> <p>There were no residents under the Long Term Services Chronic Health Care contract.</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</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement which is fully implemented. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, and clinical incidents including infections, falls, wounds and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, staff meetings and resident meetings as appropriate. Quality data is evaluated at management level. If the quality data collected identifies a negative trend a detailed corrective action is put in place to address the issue and staff are informed during handover, the residents and families are informed as appropriate and the quality assurance manager monitors the outcome. Corrective actions are signed off when completed. This process is systematically documented and shown in resident and staff meeting</p>

<p>continuous quality improvement principles.</p>		<p>minutes. The information is used to improve services and resident satisfaction where possible. Staff reported their involvement in quality and risk management activities through audit activities and implementation of corrective actions. Staff, residents and family are asked for their input for corrective action planning and this was confirmed in resident meeting minutes sighted and during resident and family interviews conducted.</p> <p>Examples of corrective actions included the internal cleaning audit which gained a 69% rating. The follow up included staff education, review of documented procedures and the introduction of a staff signing form for daily cleaning duties. The follow up audit taken after two months showed a 93% rating was gained. Following the introduction of the food safety plan, the facility has introduced a computerised quality system specifically for kitchen use only, to show that all requirements are being maintained.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey (September 2017) showed that residents would like more outings and activities. This was followed up by the service who have introduced regular weekend activities to the calendar, the outcome will be measures in the upcoming resident satisfaction survey findings. The residents interviewed on the day of audit stated they were very happy with the activities offered.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The managers are familiar with the Health and Safety at Work Act (2015) and the service has implemented requirements. The health and safety committee consisting of a range of staff from across all services monitor and report on hazards. Regular reporting is undertaken, and a full annual report is developed and sent to the owner/directors.</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</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to all members of management and a monthly report is sent to the owner/directors. The monthly report identifies trends against previously collected data, the type of incident, time of day and where the incident occurred. The recently analysed data is discussed at shift handovers and stall meetings. Corrective actions are put in place and these are shown on the resident's care plan and on documentation sighted. Short term care plans are put in place if required.</p> <p>The nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one section 31 form completed and sent to the Ministry of Health (27 July 2017) and to the DHB giving notifications of a significant event. This related to an issue with the cold chain not being maintained</p>

<p>consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>when an outside agency was carrying out influenza immunisations. This was an issue for many facilities at the time. There have been no police investigations, coroner's inquests or issues based audits since the previous audit.</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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period and then annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. In-service training and education is presented at least monthly and guest presenters have included a dietitian, physiotherapist and gerontology nurse specialist from the WDHB. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB.</p> <p>There are three trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records of this were sighted.</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 and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. There is registered nurse coverage on all morning shift.</p> <p>The activities coordinator works 9am to 3pm five days a week. The nurse manager works eight hours five days a week. The quality manager works 8am to 4pm Monday to Friday. A stock controller works eight hours per week and the administration assistant works 9am to 3pm two days a week.</p> <p>A cook works 8am to 1pm with kitchen hand assistants working 7am to 1.30pm, 4.30pm to 8pm and 3pm to 7pm seven days a week.</p> <p>Dedicated cleaning and laundry staff work eight hours Monday to Friday and four hours Saturday and Sunday.</p>

		Additional cleaning staff undertake spring cleaning two days a week from 9am to 6pm.
<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>The medication management policy is current and identifies all aspects of medicine management. A safe system for medicine management using an electronic system was observed on the day of the audit. The care staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. There are fourteen care staff with medication competencies. All competencies can be verified. There is key pad access to the medication room. The temperature of the medication fridge and medication room are closely monitored. Any variance alarms to the pharmacy direct and to the general manager.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurses check all medications against the prescriptions. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request and six monthly audits are performed. A stamp is used for the stock reviews six monthly and the weekly medication stock checks for the controlled drugs. These medications are only supplied from the pharmacy on a weekly basis and are stored appropriately to meet legislative requirements.</p> <p>Good prescribing practices were observed, and the GP interviewed is pleased with the electronic system and is able to make relevant changes from the medical practice which is advantageous. The required three monthly GP review of all medications is consistently recorded on the electronic medicine chart.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed if needed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors. This has reduced significantly with the introduction of the electronic medication system now in place.</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</p>	FA	<p>The food service is provided on site by a kitchen team and is in line with recognised nutritional guidelines for older people. The menu has been developed and implemented to cover summer and winter patterns and has been reviewed by a contracted dietitian within the last two years. The last review date was recorded as the 26 July 2018. The dietitian routinely visits three monthly and at each visit reviews approximately eight residents' nutritional profiles, especially those residents with erratic blood sugar levels, decreased weight loss, increased frailty and those with poor appetite. Recommendations made at each visit have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration was issued 25 June 2018 and is due to next expire 26 June 2019. Meat temperatures, cleaning tasks per shift and who is responsible, pest control, staff sickness, maintenance and all fridge/freezer temperature monitoring is being upgraded presently onto the new electronic programme installed. There are inbuilt processes for temperature</p>

delivery.		<p>monitoring of goods reports and summaries can be printed off. All food stuffs stored are rotated.</p> <p>The dietary requirements, likes and dislikes and/or any special diets are established on admission when the registered nurse completes the nutritional profile, as was evident in each resident's record reviewed. A copy is provided to the kitchen staff.</p> <p>The kitchen is clean and tidy and a whiteboard was sighted with all special needs documented for the residents.</p> <p>Evidence of residents' satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in the dining room in an unhurried manner and those requiring assistance had this provided.</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>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with meeting their identified needs and goals. The attention to meeting the diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is to a high standard. The care staff confirmed that care was provided as outlined in the documentation sighted. A range of equipment and resources was available suited to rest home level care and in accordance with residents' identified needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by an activities coordinator. The activities coordinator has been in this role for four years and works five hours a day (9am to 12md and 1pm to 3pm) Monday to Friday. A social assessment and history is undertaken on admission to ascertain a residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly when the interRAI assessment and lifestyle care plan is reviewed.</p> <p>The activities programme reviewed reflects the residents' objectives, ordinary patterns of life and includes normal community activities as much as possible. Individual, group activities and regular planned events are reviewed to help develop and implement a programme that is meaningful to the residents. Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings held three monthly and resident satisfaction surveys. Residents interviewed enjoyed the programme and the variety of activities available.</p>
Standard 1.3.8:	FA	<p>Residents' care is evaluated on each shift and reported in the progress records reviewed. If any changes occur, it is</p>

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>noted and is reported to the registered nurse or the nurse manager.</p> <p>The lifestyle care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessment or as residents' needs change. Where progress is different than expected, the service responds by initiating changes to the lifestyle care plan. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for wounds, urinary tract infections and other problems that arise from time to time. When necessary and for unresolved problems, the long term lifestyle care plans are added to and updated to guide the care staff. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 28 October 2018) is publicly displayed. There have been no changes to the facility footprint since the previous audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term residential care facilities and includes infections of the urinary tract, soft tissue, fungal the upper and lower respiratory tract, scabies, wound, gastrointestinal and eye infections. There is a designated registered nurse who is the infection prevention and control coordinator for this service. The infection prevention and control nurse reviews all reported infections and these are documented. Any new infections and any required management plan is discussed at handover to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular quality and staff meetings and at staff handovers between shifts. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the nurse manager. The infection rate is low at this facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The facility is restraint free with no enablers or restraints in use. The restraint coordinator provides support and oversight for enabler and restraint management in the facility should it be required. This is supported by meeting minutes sighted, the annual restraint audit carried out</p>

that the use of restraint is actively minimised.		in January each year and during staff interviews. Staff reported that restraint would only be used as a last resort when all alternatives have been explored.
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.