

Grace Comfort Care Limited - Glenhaven Resthome

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 BSI Group New Zealand Ltd, 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: Grace Comfort Care Limited

Premises audited: Glenhaven Resthome

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 9 March 2021 End date: 10 March 2021

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 19

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
Yellow	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
Red	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

Glenhaven Rest Home provides rest home level care for up to 24 residents. On the day of the audit there were 19 residents. The residents, relatives and general practitioner interviewed commented positively on the care and services provided at Glenhaven Rest Home.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures; a review of residents and staff files; observations; and interviews with residents, family, management, staff and a general practitioner.

The facility manager is supported by a clinical manager and registered nurse who provide oversight of clinical care.

The previous certification audit did not identify any shortfalls. This audit did not identify any shortfalls and the service continues meet the standards.

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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Interviews with residents and family confirmed they are provided with adequate information and that communication is open. Family members stated that they are informed of any change of care or incident related to their family member when this occurs.

Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints with these investigated in a timely manner.

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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There is a facility manager (owner/operator) and clinical manager who provide operational management and clinical management for the service. They are supported by two other registered nurses.

There is an implemented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by the nurse lead and/or clinical facility manager. All aspects of the quality programme are discussed at relevant meetings. The health and safety programme is implemented.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An annual staff education and training plan is well attended with all staff attending mandatory training as required.

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 nurses are responsible for each stage of service provision. A registered nurse completes initial assessments, risk assessments, interRAI assessments and long-term care plans within the required timeframes. Care plans are evaluated at least six-monthly and meet the resident's current needs and supports.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly.

A diversional therapist and activities coordinator implement a planned programme during the week that meets the needs of the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual and group preferences and abilities for each resident group. Residents and family reported satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met.

Safe and appropriate environment

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

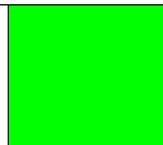


Standards applicable to this service fully attained.

The building holds a current 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.

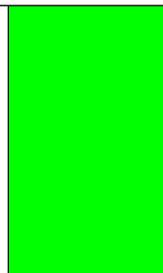


Standards applicable to this service fully attained.

The service maintains a restraint-free environment. There are policies and procedures to follow in the event that restraint or enablers were required. On the day of the audit there were no residents using restraints or enablers.

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.

A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

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	41	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 procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written, are maintained by the facility manager using a complaint's register.</p> <p>One complaint around staffing levels was signed off by the DHB with no actions required in mid-2019. A complaint in mid-2020 was lodged with the Ministry of Health and subsequently to the district health board (DHB). The complainant could not understand the need for lockdown levels of Covid-19. A behavioural management plan had already been documented and no actions were required. The complaint was closed out four months later. In each case, appropriate actions were taken within the required timeframes and to the satisfaction of the complainant.</p> <p>There have not been any complaints in 2021 to date. Residents and families interviewed advised that they are aware of the complaints' procedure.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>The following staff were interviewed: one registered nurse, the clinical manager, facility manager, two healthcare assistants (HCAs), cook, and the activities coordinator. Five residents and one family member were interviewed.</p> <p>Management promotes an open-door policy. Residents confirmed on interview that the staff and management are approachable and available. Information is provided in formats suitable for the resident and their family.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Residents and family are informed prior to entry of the scope of services and any items that are not covered by the agreement. Communication with family members is recorded on the incident report forms and in the resident daily progress notes. Twelve incident forms reviewed for 2020 and 2021 confirmed that family were notified following a resident incident. Interpreters are available as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Glenhaven Rest Home can provide care for up to 24 residents requiring care at rest home level. On the day of audit there were 18 residents requiring rest home level of care with these residents under the age-related residential care (ARRC) agreement, and one under a long-term service-chronic health condition (LTS-CHC) contract.</p> <p>The service has a strategic business plan (2020-2022) in place. The business plan includes a mission statement, values, and goals. Business goals are reviewed three-monthly as per the quarterly service review. A risk management plan is also linked to the strategic business plan and reviewed at the same time or updated if risks emerge. An organisational chart is documented.</p> <p>Glenhaven Rest Home is privately owned. The facility manager is on site five days a week and is available by phone 24/7 if not on site. The facility manager has been in aged care in management roles for 14 years with three years in the current role. The manager is supported by the clinical manager (CM) who has worked in aged care for 10 years and who works 18 hours on site including completing all interRAI assessments, care plans and reviews of care plans. The CM is supported by a registered nurse who has been working in aged care for 30 years with 10 of these being as a registered nurse. The RN works 30 hours. There is also another registered nurse who works eight hours one day a week.</p> <p>The facility manager, clinical manager and registered nurses have maintained at least eight hours annually of professional development relating to managing a rest home.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management programme is in place. Interviews with the facility manager, clinical manager and staff reflected their understanding of the quality and risk management systems that have been put into place. Policies and procedures were initially provided by an external consultant and now are reviewed by the facility and clinical managers. A system of document control is in place with evidence of regular reviews with the last review taking place in February 2021. Staff are made aware of any policy changes through staff meetings.</p> <p>A 2021 quality plan is in place. This is reviewed quarterly. Quarterly reports include trends around medications, infection control, falls prevention and restraint.</p> <p>The monthly collating and analysis of quality and risk data includes monitoring accidents and incidents, any complaints received, resident satisfaction and infection rates. Internal audits regularly monitor compliance. A</p>

		<p>corrective action form is completed where areas are identified for improvement. Evidence of resolution of issues and corrective action plan was evidenced on site. Staff are kept informed regarding results and actions via staff meetings. The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified. Annual resident satisfaction surveys are completed. The last resident satisfaction survey results (September 2020) indicated that no corrective actions were required. All respondents were very satisfied with all areas questioned.</p> <p>Meetings are held to ensure that staff and others are informed of any issues or to discuss opportunities. Monthly staff meetings include all aspects of the quality and risk management programme. There are two monthly resident meetings and family can attend. An independent advocate attends meetings once a year with the last visit taking place in October 2020. The RNs meet quarterly for informal discussions with the manager.</p> <p>A health and safety programme is in place, which includes managing identified hazards. The activities coordinator oversees the programme. Health and safety training begins during the new employee's orientation. The topic of health and safety is discussed each month in the staff meetings. The hazard register is regularly reviewed and updated as new hazards are identified.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, and corrective actions. Twelve incident forms reviewed for 2020 and 2021 evidenced that appropriate clinical care is provided following an adverse event. Investigations were completed, and family notified as appropriate. All incident forms are signed off by the clinical manager. There have been only three falls in 2021 (YTD) and there is a very low rate of incidents in the facility. All reviewed showed that neurological observations had been taken as per policy.</p> <p>The HCAs and RNs interviewed, could discuss the incident reporting process. The clinical manager collects monthly incidents, investigates, and implements corrective actions as required. Records of events are collated per individual resident and for the facility as a whole.</p> <p>Discussions with the facility manager confirmed that there is an awareness of situations in which the service would need to report and notify statutory authorities. One incident was reported to the Ministry of Health on a Section 31 after a resident absconded from the facility during lockdown. This linked to a complaint made by the family. The DHB investigated the event, and the incident was closed with no recommendations made.</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>There are human resource management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience, and veracity. Copies of current practising certificates for health professionals are held. Five staff files (one clinical manager, two RNs, one HCA and one activities coordinator) were reviewed. The records evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service.</p> <p>There is an education and training plan in place that meets contractual requirements. The clinical manager has completed interRAI training. There is a minimum of one staff available 24/7 who holds a current certificate in first aid and CPR.</p> <p>The HCAs are experienced and on the whole, long serving. One has 18 years' experience; one has a Bachelor of Social Work and two are completing level 4 training through Careerforce. One HCA is newly employed.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>The facility manager is on site five days a week and is on-call when not on site. The facility manager can contact the clinical manager at any time including after hours.</p> <p>The clinical manager works 18 hours a week and the other two RNs work a further 38 hours a week. An RN is on site six days a week.</p> <p>The roster includes two caregivers on the AM shift (one long and one short). One caregiver is rostered for the PM shift and one for the night shift. The registered nurse works until 6 pm and gives the afternoon medications. HCAs are also responsible for cleaning and laundry. Interviews with HCAs and residents identified that staffing is adequate to meet the needs of residents.</p> <p>Activities staff are scheduled Monday – Friday from 9 am – 2 pm. A cook is rostered from 7 am – 1 pm and a kitchen assistant assists with the evening meal.</p> <p>There is an upstairs and downstairs to the building. The staircase and lift are centrally located, and the staff stated that they can hear the call bells from any part of the building. There is an HCA who lives on site in the upstairs area. They are also able to be woken at any time and support staff in the evening or overnight if need be.</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>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. All legal requirements had been met. There are no standing orders in use. There are no vaccines stored on site.</p> <p>The facility uses a paper-based and robotic pack system. They are currently in the process of introducing an electronic system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication competent caregivers administer medications. Staff have up-to-date medication competencies completed and there has been medication education in the last year. The medication fridge temperature is checked daily. Eye drops, and other short course medicines are dated once opened.</p> <p>Staff sign for the administration of medications on medication signing sheets. Ten medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service has two cooks, one who works Tuesday to Saturday and one who works Sunday to Monday. Both have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals are cooked on site. Meals are served directly from the kitchen to the dining room. Meals going to rooms on trays have covers to keep the food warm. Special equipment (eg, lipped plates) is available.</p> <p>On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. The cooks prepare the evening meal and leave it for the HCAs to heat and serve. There are no residents losing weight.</p> <p>Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals.</p> <p>The food control plan was approved and is valid until December 2021. Residents completed a food satisfaction survey in April 2020, and all were very satisfied. Residents interviewed confirmed that they remained very satisfied with food services.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs change. Short term care plans were used for short-term cares (e.g., infections).</p> <p>Residents' falls are reported on incident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family is notified.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There were two blisters that had been identified as pressure injuries on a heel for one resident. These had now healed and were classed as stage one as they were being addressed to stop the resident rubbing these again. There were no other wounds.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p> <p>As part of the audit, comments relating to a DHB complaint were investigated. The audit confirmed that the post falls policy had been reviewed and updated as suggested by the DHB; the neurological observation chart following a head injury form had been reviewed to reflect best practice; and the policy and processes for weight management of residents with unintentional weight loss had been reviewed. Short-term care plans were used when required for example, in the resident files reviewed, short-term plans were used for cellulitis, infected haematoma, urinary tract infections, and an abrasion.</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>	<p>FA</p>	<p>There is an activities coordinator who works five days a week from 9 am - 2 pm. There is also a diversional therapist who works two hours on a Tuesday and two hours on a Friday. On the day of audit, residents were observed doing exercises, singing, and playing games. HCAs led the singing in the afternoon. Residents were actively engaged as a group and all said they loved the programme.</p> <p>There is a weekly programme in large print on noticeboards. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music, entertainment, outings and walks outside.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There are church services, pet therapy and van outings at least weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Fathers' Day, Anzac Day, and the Melbourne Cup are celebrated. There is community input from</p>

		<p>kindergartens, scout groups and cultural groups. Some residents independently access the community.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career, and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly, at the same time as the review of the long-term care plan.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The four long-term care plans reviewed (apart from one new admission) had been evaluated by the registered nurses six-monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activity plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP if available and resident/family if they wish to attend. There are three-monthly reviews by the GP for all residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</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>The building holds a current warrant of fitness which expires 21 February 2022. Electrical equipment has undergone annual safety testing. Medical scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well-maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>HCA's interviewed stated they have adequate equipment to safely deliver cares.</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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (registered nurse) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends, is discussed at staff and management meetings. Meeting minutes are available to staff. Trends are identified and analysed, and preventative measures put in place. There is a low rate of infections. Two incident forms were reviewed for residents with an infection. Both were linked to a short-term care plan and included in the statistics collected on a monthly basis.</p>
<p>Standard 2.1.1: Restraint</p>	FA	<p>Glenhaven Rest home has policies and procedures on restraint minimisation and safe practice. Policy</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were no residents using restraints or enablers. The restraint coordinator (clinical manager) confirmed that the service promotes a restraint-free environment. Restraint education is included in the annual training programme with this last provided in 2020.</p>
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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.