

# Pohlen Hospital Trust Board - Pohlen Hospital Trust Board

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Pohlen Hospital Trust Board	
<b>Premises audited:</b>	Pohlen Hospital Trust Board	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Hospital services - Surgical services; Hospital services - Maternity services	
<b>Dates of audit:</b>	Start date: 10 October 2017	End date: 10 October 2017
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	28	

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# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Pohlen Hospital provides rest home and hospital level care (medical and geriatric) and hospital services (surgical and maternity) for up to 33 clients. The service is operated by a charitable trust and managed by a general manager and a clinical quality manager. There have been no changes to the service and facilities since the previous partial provisional audit. Clients and families spoke positively about the care provided.

This unannounced 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 clients' and staff files, observations and interviews with clients, family members, management, staff and a general practitioner.

This audit has resulted in all required surveillance standards being met. Areas identified as needing improvement at the previous certification audit were reviewed and closed out at the subsequent partial provisional 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, clients and families is promoted and was confirmed to be effective. There is access to interpreting services if required.

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, values, a mission statement and identified areas of risk for the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages 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 clients 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. Education and training plans are suited to the scope of service provision, supports safe service delivery, and include regular individual performance review. Staffing levels and skill mix meet the changing needs of clients.

## 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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Clients' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hour each day in the facility and are supported by care and allied health staff and a general practitioner and nurse practitioner. On call arrangements for support from senior staff are in place. Midwives contracted to the service are available 24 hours a day, seven days a week and maternity assistants are rostered to cover the unit when required. Shift handovers guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All clients' records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. For women and babies, this is at each point of contact with staff or the midwife. Clients and families reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Clients are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme provides clients with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings. The focus for the maternity unit is parenting education and staff are encouraged to share information as able on safe sleeping, breast feeding and healthy living for the postnatal period for the mother and baby/pepe.

Medicines are managed according to policies and procedures based on current good practice and is consistently implemented using a manual system. Medications are administered by registered nurses, registered midwives and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of clients with special needs catered for. Policies and procedures guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Clients 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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The facility meets the needs of clients. There is a current building warrant of fitness.

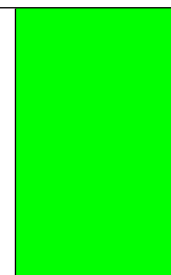
## Restraint minimisation and safe practice

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 the minimisation of restraint. One enabler and two restraints were in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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.

Surveillance of infections is undertaken. The clinical quality manager has oversight of the programme, from implementation through to collation and analysis of infection control data. Quality and staff meetings confirm that conclusions and recommendations to reduce infections are being reported and implemented.



## 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
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints and compliments policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to clients and families on admission and those interviewed knew how to do so.</p> <p>The complaints register includes complaints and feedback from clients, documents trends and action plans. The majority of feedback received are from clients of the maternity service. Two formal complaints were received over the past year, the actions taken are documented and letters sent to the complainants are completed within the required timeframe. One complaint is currently open and being processed. Meeting minutes verify communication with staff and improvements made where possible. The general manager is responsible for complaints management and follow up. All staff interviewed confirmed an understanding of the complaint process and what actions are required. There are no Health and Disability Commissioner (HDC) complaints being managed. The general manager is preparing a response to the HDC in relation to a complaint being handled by the local DHB.</p>
Standard 1.1.9: Communication  Service providers communicate	FA	<p>Clients and family members in the maternity, rest home and hospital areas stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in clients' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the</p>

effectively with consumers and provide an environment conducive to effective communication.		<p>requirements of the Code.</p> <p>There is a process to access interpreter services. Front office and management staff reported that this service has not been required as clients have managed this by using family members. If a need is identified this will be managed with support from the local district health board (DHB).</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plan 2016-2017 is currently active and outlines 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 reports to the board of directors showed adequate information to monitor performance is reported including bed status trends, staffing, financial performance, emerging risks and issues. A new strategic planning round has commenced for the year 2017-2018. Stakeholder consultation has begun with provider and community group meetings led by the general manager (GM).</p> <p>The service is managed by a General Manager who holds relevant qualifications and has been in the role for one year. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The GM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through formal education, regular meetings with the stakeholders, DHB committees, and staff meetings.</p> <p>The service holds contracts with the DHB for residential respite, Long Term Support for Chronic Health Conditions, primary care in patient services (General Practitioner clients), palliative care, transitional care and maternity care. Twenty-eight clients were receiving services at the time of audit. Of these, eight were rest home, twelve hospital, two palliative, two primary care in-patients, one respite and three maternity clients.</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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents/adverse events and complaints, audit activities, a regular patient satisfaction survey, client group meetings, stakeholder meetings, monitoring of infections and monitoring of outcomes.</p> <p>Minutes of monthly quality meetings and staff meetings reviewed confirmed the data collection and analysis of quality indicators and information. Where there was specific area related feedback and concerns (eg, food services and maternity services) this was taken directly to the providers and the clients. Food service and maternity service meeting minutes reflected the discussions. Staff reported their involvement in quality and risk management activities through audit activities and document review. The staff are currently being consulted on the hazard register which is being reviewed. Relevant corrective actions are developed and implemented to address any shortfalls. Client and family satisfaction surveys are undertaken. The general manager and quality manager also meet with a client group from the maternity and Pohlen Hospital areas. The most recent survey showed the need for lead maternity carers. This issue is currently being progressed through meetings with the DHB maternity team and discussions with the</p>

		<p>board. Due to the contracted nature of maternity service provision at Pohlen Hospital this is a complex planning issue.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to pressure injury assessment and reporting and 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 GM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>	FA	<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 at the quality meetings and staff meetings. Collated information is also reported to the board, as confirmed in meeting minutes.</p> <p>The GM described essential notification reporting requirements, including for pressure injuries. In the time period since the last audit there have been no significant events to report to the Ministry of Health. There was a sudden demise of a patient transferred from the DHB. The general practitioner was aware of the case and no coroner's inquest was required.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, validation of qualifications and practising certificates (APCs) for all staff; allied, doctors, nurses and midwives. 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 both permanent and casual reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and an annual performance review.</p>

good employment practice and meet the requirements of legislation.		Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have completed a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are two staff trained, one of whom maintains the annual competency requirements, to undertake interRAI assessments. A second RN will be supported in the coming year to complete interRAI training and maintain competency. Records reviewed demonstrated completion of the required training.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mix to provide safe service delivery, 24 hours a day, seven days a week (24/7). This document is currently under review for the year 2017-2018. The facility adjusts staffing levels to meet the changing needs of clients. An afterhours on call roster is in place shared by the clinical quality manager and general manager both of whom are RNs. There is good access to advice from the co-located GP service. Care staff and an agency staff interviewed reported there were adequate staff available to complete the work allocated to them.</p> <p>The service has dedicated cleaning, laundry and kitchen staff seven days a week. One diversional therapist covers the weeks activities. Clients and family members interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Midwives are on call 24 hours/seven days a week. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage at the facility.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medicine management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. Registered midwives have prescribing rights and medicines are charted on hardcopy records and signed on the administration record when administered to clients. Any allergies and/or sensitivities are documented if known.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Midwives have prescribing rights and midwives interviewed had attended medication prescribing updates as part of the Midwifery Council requirements. Minimal medications are stored appropriately in the maternity unit.</p> <p>Medicines are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medicines against the prescription. All medicines sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge were recorded daily and were within recommended temperature</p>

		<p>guidelines. There were no medicines currently stored in the fridge.</p> <p>There is an electronic medication management system. Best practice prescribing practices were noted and include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review is consistently recorded on the medicine records. The service does not use standing orders.</p> <p>All staff who assist with medicine management have a current competency assessment. There is one client who self-administers medicines. Processes are in place and the client has been approved by the general practitioner to do this.</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>	FA	<p>The food service is provided on site by the kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The staff have regular in-service training on the importance of nutrition and hydration for the clients. The staff have unrestricted access to food and fluids to meet the clients' nutritional needs 24 hours a day.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded. The service has developed a draft food safety plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>Evidence of resident satisfaction with meals was verified by client and family interviews, satisfaction surveys and meeting minutes. Clients were observed to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. The clients in the maternity unit have choices of food at mealtimes. Breakfast is served in the unit to meet the needs of the clients. Additional food, such as fruit, baking and biscuits is readily available for after hours if needed. Women are able to eat in the dining room or in their own rooms. Clients interviewed were pleased with the meal service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to clients was consistent with their needs, goals and their plan of care. The attention to meeting a diverse range of client's individualised needs was evident in all areas of service provision. The staff interviewed verified that medical/midwifery input is sought in a timely manner and supporting the client is based on the client's individual needs and capabilities. Care staff</p>

adequate and appropriate services in order to meet their assessed needs and desired outcomes.		confirmed that care was provided as outlined in documentation. A range of equipment and resources was available.
<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 who was previously a volunteer visiting the facility on a weekly basis. The activities coordinator has been in this role since February 2017.</p> <p>A social assessment and history is undertaken on admission to ascertain clients' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the clients. The client's activity needs are evaluated as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect clients' goals, ordinary patterns of life and include normal community activities, individual group activities and regular events are offered. Examples included crafts, live musical entertainment, concert music, bible group readings, exercise and writers group and bingo. The activities programme is discussed at the minuted clients' meeting and indicated clients' input is sought and responded to. Client and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Clients interviewed confirmed they find the programme fun and interesting.</p> <p>Activities for the maternity service are not planned and are focused on parenting education at every opportunity. Activities such as teaching about safe sleeping, baby bathing demonstrations, settling and positioning for babies, and breast feeding techniques and positioning are encouraged by all staff.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Client care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN or the midwife on call. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as clients' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds and pain management.</p> <p>When necessary, and for unresolved problems, long term care plans are added to and updated. Clients and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
Standard 1.4.2: Facility Specifications	FA	A current building warrant of fitness (expiry date 1st September 2018) is publicly displayed. Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. There is an

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		updated and approved fire service evacuation plan in place and no changes have been made to the facility footprint since this time.
<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 activity undertaken is appropriate for the type of facility and services offered. All treated infections are included in the surveillance programme. The infection control coordinator, a registered nurse reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Where trends are suspected there is evidence of staff discussion and education. Results of the surveillance programme are reported at the quality meetings and shared with staff via regular staff meetings and at staff handovers. Graphs are produced by the coordinator and displayed.</p> <p>Staff interviewed stated that they have a good understanding about the principles of infection prevention and control and education is provided regularly.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</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 restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and for their role and responsibilities.</p> <p>On the day of audit, there were two clients using restraints and one enabler was in use. Any restraint or enabler in use is the least restrictive. The use of enablers is voluntary. Restraint is used as a last resort when all alternatives have been explored. There is an annual training and competency assessment for restraint minimisation and safe practice. This was evident on review of the restraint approval group minutes, files sampled, and from interview with staff.</p>



## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.