

Little Sisters of The Poor Aged Care New Zealand Limited - St Joseph's

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Little Sisters of The Poor Aged Care New Zealand Limited
Premises audited:	St Joseph's Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 December 2017 End date: 11 December 2017
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	30

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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

St Joseph's Home and Hospital provides care for up to 31 residents requiring hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 30 residents.

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 the review of policies and procedures; the review of residents and staff files, observations and interviews with residents, staff and management.

The service is overseen by a manager, who is a Sister and is well qualified and experienced for the role and is supported by an experienced nurse manager. Residents and family interviewed spoke positively about the service provided.

The service has addressed the one shortfall from their previous certification audit around restraint monitoring.

This surveillance audit identified improvements required around open disclosure documentation, service delivery interventions, medication management and nutritional documentation.

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.		Some standards applicable to this service partially attained and of low risk.
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Families and residents interviewed reported that communication is adequate to meet their needs. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The quality and risk management programme includes service philosophy and goals. Quality activities are conducted, and these generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and managed appropriately.

Input from residents and families are regularly sought. An education and training programme has been established with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed.

A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is medication policies and procedures documented. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the activity team. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents and relatives report satisfaction with the food service.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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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St Joseph's has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were nine residents with restraint and six residents with an enabler. Restraint management processes are adhered.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	13	0	2	2	0	0
Criteria	0	38	0	2	2	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>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. They confirmed that any issues are addressed, and they feel comfortable to bring up any concerns.</p> <p>Nine staff interviewed (three registered nurses (RNs), three caregivers, one cook, two activities staff) were able to describe the process around reporting complaints. The complaints process is linked to the quality and risk management system.</p> <p>Verbal and written complaints are recorded in a complaints register. There were three complaints logged in the register for 2017 (year to date). All documentation pertaining to each complaint was reviewed. Complaints lodged had a noted investigation. Timeframes determined by the Health and Disability Commissioner (HDC) were met, and corrective actions and resolutions were in place if required. Results are fed back to complainants.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	<p>PA Low</p>	<p>Residents interviewed (two rest home and three hospital) stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incident/accident forms reviewed identified that family notification</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>is not consistently being documented. Two relatives interviewed (hospital level) confirmed that they are notified of any changes in their family member's health status.</p> <p>Interpreter services are available if required. Staff and families are used in the first instance.</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>St Joseph's is owned and operated by the Little Sisters of the Poor. The service provides rest home and hospital level (geriatric and medical) care for up to 31 residents. On the day of the audit, there were 30 residents (3 rest home level and 27 hospital level). All were under the age related residential care (ARRC) contract.</p> <p>All rooms are dual-purpose. The facility manager is a sister of the order and has many years' experience in aged care management. She is supported by a nurse manager/RN who has been in her role for 18 months and has five years of management experience in aged care.</p> <p>St Joseph's has a business/strategic plan and a quality and risk management programme in place. The organisation has a philosophy of care, which includes a mission statement. The managers have each completed a minimum of eight hours of professional development over the past 12 months.</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>There is a business/strategic plan that includes quality goals and risk management plans. Interviews with the managers and staff and the review of meeting minutes confirmed that quality data is discussed at staff meetings. The quality and risk management programme is designed to monitor contractual and standards compliance.</p> <p>The service's policies are reviewed at least every two years. Staff have access to policies and procedures. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Survey results for 2017 indicated a high level of satisfaction.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse,</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. A registered nurse conducts a clinical follow-up of each adverse event. The nurse manager investigates all accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. Twenty-six incident forms reviewed for 2017 demonstrated that appropriate clinical follow-up and investigation</p>

<p>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>occurred following incidents. Missing was consistent evidence that family had been informed (link 1.1.9.1). Discussion with the nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. This has not been required since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed (two registered nurses and three caregivers) and there is evidence that reference checks were completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2017 is being implemented. A staff training plan is in place that exceeds eight hours per year. Attendance at in-service training is below average and the service is working on this. The registered nurses are able to attend external training, including sessions provided by the local DHB. Five of eight RNs attended a study day by the DHB on 24 Nov 2017. Annual staff appraisals were evident in all staff files reviewed.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The nurse manager is available four days a week.</p> <p>There is a minimum of one staff registered nurse on at any one time. Two staff RNs cover in the absence of the nurse manager (Wednesdays) and during Dr rounds (Tuesdays). Five caregivers are scheduled for the am shift, two for the pm shift and one for the night shift. Agency staff are used when required to fill vacancies. Activities staff are available seven days a week.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12:</p>	<p>PA</p>	<p>The medication management system includes a medication policy and procedures that follows recognised</p>

<p>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>Moderate</p>	<p>standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. The service uses a four-weekly package system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy.</p> <p>Medication orders did not always include 'indications for use' of 'as required' medicines and short-term medications do not always have a stop date.</p> <p>A registered nurse was observed administering medications and followed correct procedures. A review of the medication trolley found that one medication dispensed for one resident was being administered to another. Short-life medications (i.e., eye drops and ointments) are dated once opened.</p> <p>Education on medication management has occurred with competencies conducted for the registered nurse with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. No residents self-administer medicines.</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>PA Low</p>	<p>The service employs one chef and one kitchen hand Monday to Friday and one cook and one kitchen hand at the weekend. All have current food safety certificates. The weekday chef oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked onsite. Meals are served from bain maries in the dining rooms. Special equipment such as lipped plates is available. On the day of audit, meals were hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits and resident satisfactions surveys are implemented to monitor performance. Kitchen fridge, food and freezer temperatures were monitored and recorded weekly. These were all within safe limits. The residents have a nutritional profile developed on admission that identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs are not always communicated to the kitchen. Special diets, and likes and dislikes were noted in a kitchen folder. An external dietitian has audited and approved the menus. Residents and families interviewed were very happy with the meals provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	<p>PA Moderate</p>	<p>Service delivery is guided by inter-shift handovers and the resident's plan of care. Care plans sampled were goal orientated and reviewed at six monthly intervals (for long-term residents). The interRAI assessment process informs the development of the care plan, however not all triggers from the interRAI assessment were fully covered in care plans and care plans did not include all information to guide caregivers. The shortfall identified at their previous audit remains an area for improvement.</p> <p>The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary.</p>

<p>assessed needs and desired outcomes.</p>		<p>There were five identified wounds at the time of the audit including two grade two pressure injuries (one facility-acquired and one non-facility acquired). Assessments, management plans and documented reviews were in place for all wounds; however, there was no interventions to guide carers in either long-term or short-term care plan format around the current skin integrity needs.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available three days during the week to assist with mobility assessments and the exercise programme.</p> <p>Monitoring records sighted (weights, food and fluids and turning charts) were in place.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</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 are two activity staff (one sister works full-time, and one activities coordinator works part-time) who lead the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities for five days a week plus films on Saturdays.</p> <p>Group activities are provided in a communal room, in seating areas and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance. Individual activities are provided in resident's rooms or wherever applicable.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly, and a copy of the programme is available to all residents and families. The group programme includes; daily Mass, concerts, scenic drives, hair dressing, exercises lead by the physio, school visits and residents being involved within the community with social clubs, churches and schools.</p> <p>Each newly admitted is assessed on or soon after admission. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>Residents interviewed praised the activity staff and the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Care plan evaluations are signed as completed by the RN. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident and had been evaluated and closed or</p>

comprehensive and timely manner.		transferred to the long-term care plan if required. (Link to 1.3.6.1 for wound care).
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is posted in a visible location (expiry 8 April 2018).
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance continues to be an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted-upon in a timely manner. Reports are easily accessible to the nurse manager and RNs. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were nine residents with restraint and six residents with an enabler. A registered nurse is the designated restraint coordinator. One enabler file was reviewed. It was documented that enabler use was voluntary with consent provided by the resident. All necessary documentation had been completed in relation to the enabler. Staff interviews, and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Education on RMSP/enablers has been provided.
Standard 2.2.3: Safe	FA	Restraint is put in place only where it is clinically indicated and justified. A restraint register is maintained.

<p>Restraint Use</p> <p>Services use restraint safely</p>		<p>A restraint assessment is completed for all residents using restraints and enablers. Two residents' files reviewed with restraint in use (bedsides and lap belts) included restraint assessments that identified any associated risks. The corresponding care plans also indicated restraint use. Monitoring forms reflected regular monitoring at the frequency determined by the risk level. This previously identified shortfall is now being met by the service.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Interviews with residents and families confirmed that communication occurs in an open and transparent manner. The accident and incident form includes information regarding families being contacted following an adverse event. This was not being completed by staff in a consistent manner.</p>	<p>Fifteen of twenty-six accident/incident forms reviewed did not include information that family had been contacted following an adverse event.</p>	<p>Ensure the accident/incident form contains evidence of family being contacted (or if not, an explanation why they were not contacted).</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate</p>	PA Moderate	<p>There are policies and procedures in place to ensure that staff are given correct guidance for the management, storage and documentation of medication. Shortfalls were identified</p>	<p>(i)Eight of ten medication charts reviewed did not include a ‘stop date’ for short-term medication. For one resident this meant that eye medication charted for one week, with a further week charted if needed, had been administered for a month. (ii) Five of ten</p>	<p>(i)Ensure that short-term medications have a documented ‘stop date’. (ii) Ensure that ‘as required’</p>

prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		around medication management.	medication charts did not include indications for use of 'as required' medicines and (iii) one eye medication dispensed for one resident was being administered to another resident (who was also prescribed this medication).	medications include indications for use and (iii) ensure that medications prescribed are administered to that resident. 30 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents' dietary needs are not always communicated to the kitchen staff. Special diets can be catered for and alternative meals can be accommodated if needed.	Nutritional needs as stated in the care plans was not documented as communicated to the kitchen. Three of five care plan's nutrition information did not match the information documented in the kitchen	Ensure that the kitchen is aware of the nutritional needs of the residents 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	The care provided to residents was of a high standard as agreed by relatives and residents interviewed and also observation. Staff interviewed were very knowledgeable regarding the care and support needs of individual residents. All resident had a current care plan in place, but care plans did not include the detail needed to ensure care documented was personalised and addressed all needs.	(1)For hospital level care: (i) two residents with wounds did not have the interventions documented around the current skin integrity issues, (ii) two residents with increasing behavioural issues did not have de-escalation interventions documented in sufficient detail to guide staff. (iii) Interventions were not documented for one resident in relation to risks associated with warfarin. (2)For rest home level: (i) One resident did not have interventions documented for; high falls risk, use of oxygen, a sensor mat and blindness. (ii) One resident did not have	Ensure that care plans document the care and support needed to provide care for residents 60 days

			interventions for personal privacy (identified as a particular issue) and the use of heel protectors.	
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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.