Heritage Lifecare Limited - Granger House Lifecare

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Granger House Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 October 2020 End date: 13 October 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	62

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Granger House Lifecare provides rest home and hospital level care for up to 70 residents. The service is operated by Heritage Lifecare Limited and managed by a care manager and a clinical services manager. Residents and families are satisfied with the care and support being provided at Granger House Lifecare and were positive about changes that have occurred in this facility.

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

This audit confirmed that all of the standards reviewed are fully attained. Improvements have been made to residents' care plans, which has addressed an area requiring improvement at the previous audit.

Consumer rights

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

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

Information about the complaints process is provided at the time of admission and is available at the front entrance. Complaints are being fully investigated and responded to. 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.

An organisational business plan for Heritage Lifecare Limited includes overarching goals, action plans, scope, direction, values and mission statement. A business plan for Granger specifically focuses on how this facility will meet the key performance indicators from the organisational plan. Regular monitoring reports about the services are provided to the governing body. An experienced and suitably qualified person manages the facility.

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

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

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.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

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

Safe and appropriate environment

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

There is a current building warrant of fitness on public display. No modifications have been made to the facility since the previous audit.

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 organisation has implemented policies and procedures that support the minimisation of restraint. Four enablers and three restraints are in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	40	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	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 residents and families on admission and the manager informed it is a topic in residents' meetings and in staff education sessions. Residents and family members interviewed knew how to do so. This was confirmed in completed complaint forms sighted. An electronic complaints register reviewed showed that a total of 13 complaints (four verbal and nine written) have been received over the past year and that actions taken, through to a resolution, are documented and completed within the required timeframes. The care manager, who is responsible for complaints management and follow-up, noted there is not always confirmation of satisfaction with the resolution form the complainant. Action plans show any required follow up and improvements have been made where possible. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. One Health and Disability Commission complaint is under investigation. Previous investigations by the Coroner's office and by the police have not been upheld and no recommendations were made. The issue is currently under legal review and is therefore ongoing.
Standard 1.1.9: Communication	FA	The care manager and the clinical services manager confirmed they accept responsibility for open disclosure processes. Residents and family members stated they were kept well informed about any changes to their/their

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		relative's status. This includes incidents, or accidents and outcomes of regular and any urgent medical reviews. Dates and times of when relatives were informed are recorded on the completed incident reports sighted. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Organisational policies and procedures describe residents' rights to interpreter services when required and how to access them. The care manager noted that interpreter services are available through the Grey Hospital and Health Centre, West Coast District Health Board but to date have never been needed. Staff noted individual communication needs are constantly considered as many are hearing impaired, visually impaired, or have speech difficulties.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	There is a Heritage Lifecare Limited (HLL) organisational business plan, which is reviewed annually. This outlines the purpose, values, scope, direction and goals of the organisation and sits alongside a Granger House Lifecare specific business plan. The documents describe annual and longer-term objectives under each goal and include key performance indicators and associated operational plans. A sample of these weekly and monthly reports that are sent to the HLL support office were viewed and include details such as occupancy, financial performance, staffing reports, complaints, incidents/adverse events, infections, restraint use and emerging risks. A suitably qualified and experienced care manager is responsible for management of the facility. The care manager has more than 40 years in the health sector and has been in the current role for two years. Responsibilities and accountabilities are reportedly defined in a job description and an individual employment agreement, although these were not able to be viewed as they are held at the support office. Qualifications include enrolled nurse, a business degree with postgraduate papers in health services management that are now being used towards an almost completed master's in health service management. The care manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through regular attendance at local West Coast ARRC meetings, HLL management meetings and is a member of the dementia stakeholder's group (West Coast). The service holds Aged Related Residential Care (ARRC) contracts with the West Coast District Health Board, to provide hospital and rest home care services, including for respite care. It also has one for end of life care. There are currently 33 residents receiving hospital level care under the ARRC agreement, three others are under contracts with the Accident Compensation Commission and three under Ministry of Health contracts for young person's with disabilities. Twenty-three people are receiving rest home level care, all of which are under the ARRC agreement.
Standard 1.2.3: Quality And Risk Management Systems	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and falls for example and risk management.

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		Minutes were reviewed for monthly quality and risk management meetings, staff meetings and departmental meetings. These confirmed regular review and analysis of quality indicators is occurring, and related information is reported and discussed. Relevant corrective actions are developed and implemented to address any shortfalls. During interviews, staff reported their involvement in quality and risk management activities through assisting with internal audits, keeping updated with organisational policies and procedures and reporting incidents and any concerns. Quality indicator data is collated and provided to the HLL support office. Monthly analyses of this data against key performance indicators are available. Resident and family satisfaction surveys are completed annually. The most recent survey undertaken mid-2020 showed concerns about food and about staff being difficult to understand or using their own language. Actions are underway to address both issues. There were favourable comments about staffing, how good the staff are and about activities, although the care manager expressed an intention to improve the activity programme even further. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The care manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. These included strategies in place to manage the risks associated with the Covid-19 pandemic. Parts of the risk management processes are completed in collaboration with HLL operations manager, parts within the quality and risk system and individual risks for residents are reviewed in consultation with the clinical services manager. The care manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau	FA	As per the organisational policies and procedures, 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. For example, completed post fall assessment forms and neurological observations are attached to the form and recommendations and corrective action plans detailed on the reverse as appropriate. Copies of the forms are placed in an incident folder with the original placed retained in the resident's (or staff person's) file. Adverse event data is collated, categorised, analysed and reported to the HLL support office in monthly reporting quality indicator data records. The registered nurse described a project aimed at reducing the incidence of resident falls and another on the prevention of urinary tract and upper respiratory tract infections. These are demonstrating early signs of continuous improvement practices. The care manager described essential notification reporting requirements, including for pressure injuries, outbreaks and unexpected deaths. They advised there have been no notifications of significant events made to the Ministry of

of choice in an open manner.		Health since the previous audit, except to advise of a change in the clinical services manager.
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.	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes a formal application, an initial interview, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Documentation sighted confirmed all registered health professionals who have contact with residents at Granger House Lifecare have a current APC. Staff orientation includes all necessary components relevant to their specific role. Staff reported that the orientation process prepared them well for their role and that additional time may be allocated depending on previous experience. According to staff records reviewed orientation checklists are completed, as are all required competencies. Most included evidence of a performance review after a three-month period. Continuing education is planned according to the mandatory requirements, which are included in the annually reviewed HLL training calendar and staff are required to undertake the minimum as outlined. Multiple additional opportunities are provided. The care manager, who is a strong advocate for training, has developed a number of additional training resources for facility staff and added topics of interest. Attendance/participation records are completed for each opportunity and the staff training database updated accordingly. To meet the requirements of the provider's agreement with the DHB, care staff have either completed or commenced a New Zealand Qualification Authority education programme, with most at least level three or above. The care manager is the internal assessor for the programme. Three of the eight longer servicing registered nurses are maintaining their annual competency requirements to undertake interRAI assessments and the clinical services manager informed this is proving sufficient. A database reviewed demonstrated annual performance appraisals are being completed within expected timeframes.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents and makes every effort to maintain stable staffing for residents with staff dedicated to rest home or hospital as far as possible. Additional staff may be called on by any registered nurse if workloads indicate the need, but this is most often done by the care manager or the clinical services manager. The facility manager and the clinical services manager share afterhours on-call, with staff confirming there is at least one registered nurse on duty in the hospital 24/7 and another in the rest home on both morning and afternoon shifts. All staff interviewed reported there is good access to advice when needed. Care staff also reported there were adequate staff available to complete the work allocated to them. Residents and family 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

service providers.		absence. A 'floating' staff person is now rostered for a short afternoon shift as part of the falls prevention project and early indications are that this is helping reduce the number of such incidences. Registered nurses are given additional time to complete required paperwork and all registered nurses and the diversional therapist/activities coordinator have a current first aid certificate, as do the receptionist and the maintenance person as they often drive the van for residents' outings.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription and enters them into the system. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. 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. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. There are no residents who self-administer medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's	FA	The food service is provided on site by a cook and 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 (23 January 2020). Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by

individual food, fluids and nutritional needs are met where this service is a component of service delivery.		Grey District Council current until 17 January 2021. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have completed relevant food handling training as evidenced in staff files. 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. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a good standard. Care staff confirmed that care was provided as outlined in the documentation and that they had opportunity to have input in the care planning process. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs such as pressure relieving devices.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a	FA	The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy and an activities coordinator who has commenced her training. A social profile and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated on a daily basis in response to residents' feedback and engagement as well as part of

consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		the formal six- monthly care plan review. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered with community involvement from entertainers. Residents are advised of each day's activities via a calendar in their rooms, a noticeboard in the lounge and an invite from activity staff during a daily visit to each resident's room. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings. Residents interviewed confirmed they find the programme varied and interesting.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. The stop and watch system of review is used if care staff see a change in a residents' condition. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' 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 and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. Multidisciplinary meetings are held six-monthly and family have opportunity for input.
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 issued 1 July 2020 with a twelve-month timeframe is publicly displayed. There have been no modifications made to the facility since the previous certification audit, although remedial work was undertaken with smoke alarms due to the frequency of false fire alarm callouts.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, and the upper and lower respiratory tract. The Infection Prevention Coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required

with agreed objectives, priorities, and methods that have been specified in the infection control programme.		actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the care home manager and quality committee. Data is benchmarked externally within the group. There have been no outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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 coordination role is undertaken by the clinical services manage. This person 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 their responsibilities. Documents describe restraint related responsibilities and accountabilities of the care manager, the clinical manager, restraint coordinator, registered nurse and enrolled nurses and caregivers. On the day of audit, three residents were using restraints and four residents were using bed rails as enablers, at their own request. There is a similar process for the use of enablers as is used for restraints. A restraint register records approvals and reviews of enabler and restraint use. Staff described the restraint monitoring processes, which were confirmed in files reviewed.

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, these 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.