

# Leslie Groves Society of St John's (Roslyn) - Leslie Groves Home

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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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Leslie Groves Society of St John's (Roslyn)

**Premises audited:** Leslie Groves Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 12 November 2020 End date: 13 November 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:** 28

# 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
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

Leslie Groves rest home is owned and operated by the Society of St John's (Roslyn) and provides care for up to 34 rest home level residents. On the day of the audit there was 28 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, and management.

The non-clinical village manager is based at the hospital site (sister facility) and has been in the role for six months. He is supported by the clinical manager (registered nurse also based at the hospital site), the rest home unit coordinator (registered nurse) a registered nurse and a team of long-standing experienced rest home staff. The residents and the relative interviewed were complimentary of the care received.

This audit identified shortfalls around internal audits, and controlled drug checks.

## 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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A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The unit coordinator is responsible for the day-to-day operations. A quality and risk management programme for 2020 is in place. Quality data has been discussed at meetings. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for 2020 programme has been implemented, which includes in-service education and competency assessments. Residents, relatives and staff report that staffing levels are adequate to meet the needs of the residents.

## 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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The unit coordinator and registered nurse are responsible for care plan documentation. InterRAI assessments and care plans are completed and reviewed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and relatives commented positively around the activities programme. The service uses an electronic medication management system. An external contractor provides food services. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Residents were complimentary of the food services.

## 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 preventative and reactive maintenance programme in place. Hot water temperatures are checked monthly. The facility provides easy access to all communal areas both internal and external for residents using mobility aids.

## 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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Leslie Groves rest home has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service currently has no residents requiring restraint or enablers.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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. The unit coordinator and the registered nurse are responsible for infection control at Leslie Groves Rest Home. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. Infection control issues are discussed at both the management and rest home quality/staff meetings. The infection control programme is linked with the quality programme.

Covid19 was well managed, logs were maintained, and contact tracing measures remain in place. There have been no outbreaks since the previous audit. Adequate supplies of personal protective equipment were sighted.

## 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	14	0	1	1	0	0
Criteria	0	38	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Complaints forms are available on the notice boards of the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the unit coordinator on the complaints register. There have been no complaints received since the last audit. Documentation and correspondence of previous complaints reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Caregivers interviewed confirmed that complaints/ concerns and any required follow-up is discussed at staff meetings. Residents and the relative advised that they are aware of the complaints procedure and how to access forms and would feel comfortable talking to the unit coordinator or the registered nurse if they had concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Comprehensive information is provided at entry to residents and family/whānau. Four residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. The unit coordinator was available to residents and relatives and promotes an open-door policy. Incident forms reviewed for October and November 2020 evidenced that relatives had been notified on all occasions. The relative interviewed advised that they are notified of incidents and when residents' health status changes promptly. The unit coordinator, registered nurse, four caregivers, one activities coordinator interviewed fluently describe instances where relatives would be notified.</p>

conducive to effective communication.		
<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>Leslie Groves is owned and operated by the Society of St John's (Roslyn). The board of trustees is made up of a group of 10, who meet monthly and provide a governance role. The facility manager attends the board meetings and presents a report prepared by the clinical manager.</p> <p>The service provides care for up to 34 residents at rest home level care. On the day of the audit, there were 28 residents. Twenty -seven residents were under the Aged Related Residential Care agreement (ARRC) and one resident was on respite care.</p> <p>Leslie Groves Rest Home is managed by the facility manager at the sister facility (Leslie Groves hospital). He has been in his role for six months and has a background in registered nursing and management roles. The rest home is managed by a unit coordinator who has been in the role since January 2020 and has been a registered nurse at the facility for six years and has a background in age care. They are supported by a clinical manager who is based at the sister facility, and a team of long serving staff.</p> <p>The 2020 strategic plan and operations/ quality plan remain in draft format due to the changes in management. The draft operations and quality plan include goals for all aspects of the service including staffing, education, clinical and quality systems and improving the resident and relatives experience.</p> <p>The facility manager has attended in excess of eight hours required training around leadership and management of an age care facility. The unit coordinator has completed education sessions including a leadership study day, and palliative care training days.</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>	PA Low	<p>The 2020 annual strategic plan and the operations quality plan was in draft form on the day of the audit. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data collected is analysed and compared monthly and annually for a range of adverse event data. Where improvements are identified, corrective actions are developed, implemented and regularly evaluated.</p> <p>Quality data from all meetings are discussed at the monthly rest home quality/ staff meeting, and the company management meetings. Meeting minutes evidence quality data, trends and analysis including areas for improvement around infections, accidents and incidents, health and safety, restraints/enablers, concerns/complaints, internal audit outcomes and quality goals. Information is shared with all staff as confirmed in meeting minutes and during interviews.</p> <p>The unit coordinator and registered nurse complete the internal audits, and corrective actions which are implemented, reviewed and resolved on the electronic system. Corrective actions sighted, had been completed and</p>

		<p>closed out as documented in meeting minutes, however, internal audits completed in 2019 could not be located.</p> <p>Annual resident/relative satisfaction surveys have been completed which identified positive results around care and support, communication, being treated with respect and dignity and being fully informed.</p> <p>Leslie Groves has contracted an external health and safety contractor to review all policies, procedures and hazard registers. There is a risk management plan in place. There is a monthly health and safety meeting held at the sister site for all units. The committee includes a representative from all areas of the facilities. A report is forwarded to the management meeting and the board, findings are discussed at the rest home quality/ staff meeting. The rest home representative (interviewed) has completed levels one and two of health and safety training. Staff receive health and safety training during orientation and ongoing training is provided. Contractors complete a health and safety induction. Actual and potential risks are documented on the hazard register (last updated in November 2020).</p> <p>Falls management strategies for residents are assessed on an individual basis.</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>Leslie Groves rest home collects incident and accident data and reports aggregated figures monthly to the quality meeting. Paper based incident reports are completed by the caregivers, the resident is reviewed by the RN or the senior caregiver at the time of event. The incidents are reviewed either by the unit coordinator or the registered nurse and entered onto the electronic system. Ten electronic incident forms reviewed identified registered nurse follow up. Incident/accident forms include a section to record relatives have been notified. Minutes of the combined quality/staff meetings reflect a discussion of incident stats and analysis. The caregivers interviewed could discuss the incident reporting</p> <p>Discussions with the unit coordinator and the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no notifications required to be made since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	FA	<p>A list of practising certificates is maintained. Five staff files were reviewed (the unit coordinator, one registered nurse, and three caregivers). All had relevant documentation relating to employment, and current appraisals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and orientation checklists (sighted in files). Staff interviewed were able to describe the orientation process and reported new staff were adequately</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>orientated to the service.</p> <p>There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. Interviews with caregivers confirm participation in the Careerforce training programme. A competency programme is in place that includes annual infection control, manual handling, medication administration and second checker competency for staff administering medications. Competency questionnaires were sighted in reviewed files. The unit coordinator and registered nurse are interRAI trained. Caregivers are encouraged to gain qualifications through the New Zealand Qualification Authority (NZQA), currently there are two caregivers with level 4, three with level 3 and one with level 2.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a total of 14 staff. There is a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The unit coordinator /RN works full-time Monday to Friday on week one and Monday to Thursday week two. The registered nurse works Monday to Thursday week one and Tuesday to Friday week two from 8am to 4.30pm. Residents, relatives and staff interviewed stated there were sufficient numbers of staff on duty to safely deliver residents cares.</p> <p>Morning shifts has three caregivers from 7am to 3.30pm (at least one of whom is medication competent).</p> <p>Afternoon shifts has three caregivers from 2.30pm to 11pm or two caregivers from 2.30pm to 11pm with one casual caregiver from 3.30pm to 9pm.</p> <p>On night shift there are two caregivers from 10.45pm to 7.15am. there is at least one medication competent caregiver on each shift. The activities coordinator works Monday to Friday. The unit coordinator and the registered nurse share on call.</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</p>	<p>PA Moderate</p>	<p>Ten electronic medication files were reviewed. All had photo identification, allergies recorded, and all medications were clearly and appropriately prescribed including indications for use. The service uses two weekly robotic rolls which are delivered by the pharmacy and checked and signed for by the registered nurse. Standing orders were not in use. Medication reviews were completed by the GP three monthly. PRN medications were prescribed correctly with indications for use. Medications are stored securely in the locked nurses' station. There were no self-medicating residents. The unit coordinator, registered nurse and 11 caregivers have current medication competencies. The medication fridge temperatures have been monitored daily and temperatures were within the acceptable range. The medication room temperatures have been recorded, and remain under 25 degrees Celsius, a fan is in place to cool the room if the temperature gets hot, however the controlled drug check was not always completed on a weekly basis.</p>

guidelines.		
<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>A food control plan is in place. There is an external contractor providing the food services for both Leslie Groves sites. The contracted company uses a commercial kitchen at the hospital site. A dietary assessment is completed by the unit coordinator or registered nurse as part of the assessment process and this includes likes and dislikes. Fridge and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridge and freezers was covered and dated. The external contractor conducts audits as part of their food safety programme. Special or modified diets are catered for, and soft and puree dietary needs are documented in files sampled. This includes consideration of any particular dietary needs (including cultural needs).</p> <p>Food is transported to the rest home via hot boxes and transferred to the pre heated bain-marie. Staff record the temperature of hot and cold dishes prior to serving. The kitchen assistant interviewed describes the temperature checking and recording, and the processes around the delivery of the food and heating the bain-marie. Cleaning schedules were maintained. Resident and the relative interviewed were complimentary of the food service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes, the unit manager, initiates a referral e.g. to the physiotherapist, dietitian, speech and language therapist. The GP actions external medical referrals when required. The care plans reviewed were current, and reflected the assessments conducted and the identified requirements of the residents. Caregivers follow the care plan and report progress against the care plan in the electronic progress notes.</p> <p>Adequate supplies of wound dressings were sighted on the day of the audit. There were four wounds on the day of the audit (one chronic leg ulcer, one large skin tear, one cancerous lesion and one blister). All wounds had individual paper-based assessments, plans and evaluations completed each time the wound was dressed. These are linked to electronic short-term care plans.</p> <p>Contenance products are available and resident files include a contenance assessment and plan. Specialist contenance advice is available as needed, and this could be described.</p> <p>A suite of monitoring charts is available on the electronic system. Monitoring charts sighted included weight, vital signs, food and fluid charts and blood sugar monitoring and were completed as per care plan interventions.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	FA	<p>The activities coordinator has worked at the service for 18 months and is completing the level 4 diversional therapy NZQA qualification. The activities coordinator works 35 hours a week between Monday and Friday. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. On the day of audit, residents were observed in the church service, participating in group games and sing-along. The programme is developed monthly and displayed in the lounge. The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and relatives. The residents and the relative interviewed spoke positively about the activities programme. The programme is comprehensive and</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>includes van outings, church services, daily exercises, pampering, word games, social drinks, making Christmas decorations and group games. Residents are supported to achieve activities such as going to the supermarket. There are resources available for staff to use for one-on-one time with the residents and for group activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plan evaluations were sighted in resident files reviewed. Evaluations have been completed three monthly and when there is a change in condition or care requirements, and document progress toward achieving goals. There is at least a three-monthly review by the GP. The files reviewed included examples where changes in health status had been documented and followed up. Short-term care plans reviewed had been evaluated and closed out or added to the long-term care plan where the problem was ongoing.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Preventative and reactive maintenance schedules are in place. The maintenance person (interviewed) works between the two facilities and dedicates two days for the rest home facility. External contractors are available 24/7. Hot water temperatures are checked randomly on a monthly basis and have consistently been recorded around 44 degrees Celsius, however, the building warrant of fitness has expired. This was delayed due to Covid 19, one area was identified as non-compliant. The service had been working alongside an external contractor to fix the non-compliance. This has been addressed and a current certificate was obtained. Electrical testing and tagging occur annually.</p> <p>The facility is spacious, with a large open plan lounge/ dining area, is all on the same level providing ease of access to all internal and external areas for residents requiring mobility aids. Resident meeting minutes sighted evidence discussions around upgrading the internal courtyard with new furniture and planting.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p>	<p>FA</p>	<p>Systems in place are appropriate to the size and complexity of the facility. The infection control coordinator (unit manager) collates information obtained through electronic individual infection logs. Trends are identified and analysed, and preventative measures put in place. Infection control data is discussed at the bi-monthly infection control committee meeting and staff meetings. Data and graphs of infection events are available to staff. The service completes monthly, six monthly and annual comparisons of infection rates for types of infections. There have been no outbreaks in the rest home since the previous audit.</p> <p>Covid19</p> <p>A Covid19 working group was developed to review policies and procedures, consider staff allocations, management of visitor restrictions, supplies and management of the different levels of lockdown. Extra training was held around the donning and doffing of personal protective equipment, hand washing, cough etiquette and cleaning and laundry</p>

control programme.		<p>processes. All rest home staff completed an infection control competency in March 2020. A resource folder was prepared with current ministry of health guidelines and regulations for staff to access. Logs of temperature checks were maintained; processes were implemented around staff coming and going from work. Residents and relatives were updated through emails and they were able to phone the facility at any time to speak to their loved one. Cleaning has remained at a high standard. The housekeeper/ kitchen assistant interviewed was fluent in the chemicals required and the importance of cleaning to a high standard, especially around high touch areas. Adequate supplies of personal protective equipment were sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint minimisation and safe practice policy that is applicable to the service. The unit coordinator is the restraint coordinator. There are currently no residents using restraint or enablers. All staff have completed restraint/enabler and challenging behaviour annually last held in 2019. Caregivers interviewed could fluently describe the differences between restraint and enablers.</p>

## 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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	An electronic system has been implemented and includes internal auditing. Clinical and non-clinical internal audits have been completed as scheduled in 2020, however, could not be located for 2019.	There is no evidence of the internal audits completed in 2019.	<p>Ensure records of all internal audits are maintained.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal,</p>	PA Moderate	There is an electronic medication charting system in use. All staff who administer medication had completed competencies. All charts sampled have been reviewed at least three-monthly. The pharmacy undertakes a balance of controlled drugs when checking in the medications, however, the weekly controlled drug checks were not always occurring	Weekly controlled drugs have not been consistently checked with	Ensure controlled drug checks occur on a weekly basis as per

and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		on a weekly basis.	gaps of three weeks noted.	policy  60 days
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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.