

Heritage Healthcare Limited - Karetu House

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 Q-Audit 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 Healthcare Limited

Premises audited: Karetu House

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 7 June 2018 End date: 7 June 2018

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: 43

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

Keratu House provides rest home level care for up to 43 residents. The service is operated by Heritage Healthcare Limited and is managed by an experienced manager. One of the areas of expertise of the service is providing care and support to residents who required input from community mental health and the service has a close liaison with the Auckland City Mission, relevant social workers and other referrers. The service provides residents with linkages in the community and encourages residents to be as independent as they can be. Residents, family/whanau reported satisfaction with the care and services provided.

This surveillance audit was conducted against a subset of the relevant Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included the review of documentation, observations and interviews. There have been no changes to the organisation since their last audit.

The four areas of improvement from the previous audit have been effectively closed out.

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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There is evidence of open disclosure in residents' records reviewed. Interpreting services are available if required. A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of services provided to the owner/directors is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies any trends and leads to improvements. Staff are involved and feedback is sought from residents. Adverse events are documented and corrective actions are implemented. Actual and potential risks including health and safety risk are identified. Policies and procedures support service delivery and are current and reviewed regularly. The appointment, orientation and management of staff is based on good practice. A systematic approach to identify and deliver ongoing education supports safe service delivery and includes regular individual appraisals being completed. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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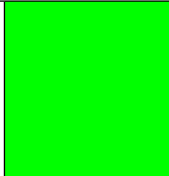
The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach. Residents receive services in a competent and timely manner in order to meet their assessed needs. Care plans are resident focused, integrated, completed and evaluated in a timely manner. Residents and their family/whanau where appropriate are involved in the care planning process. The general practitioner reviews residents in a timely manner.

The medicine management system implemented manages the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation that complies with legislation, protocols and guidelines. All staff who administer medication have current medication administration competencies. There is a medication self-administration policy with clear guidelines of the process for staff use when required.

Activities provided are appropriate to meet the needs, age, culture, and setting of the service. The activities reflect the ordinary patterns of life and include involvement of other representatives and other community groups.

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Residents' personal food preferences are met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness which expires 15 June 2018. The warrant of fitness is displayed in the office at the entrance to the facility. There have been no changes to the facility since the last 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.

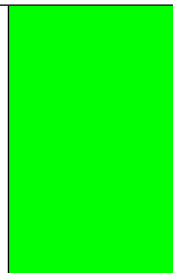


Standards applicable to this service fully attained.

There is a restraint minimisation policy that promotes safe restraint use. The policy states that the use of enablers shall be voluntary and that restraint is to be used as the last resort when all other alternative methods have been trialled first. Staff demonstrated understanding of the restraint approval process in place. There were no residents using restraint/enablers on the day of the audit.

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.

The manager and all staff take the responsibility for surveillance activities and promote surveillance monitoring as one of the quality assurance programme impacting on the residents' safety. Surveillance of infections is carried out in accordance with agreed objectives and methods that have been specified in the infection control programme. There were no infection outbreaks reported since the last audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	18	0	0	0	0	0
Criteria	0	42	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of the Right 10 of the Code. The information is provided to residents and family on admission and there is a complaint information brochure and forms available at the entrance to the facility.</p> <p>The complaints register showed that there have been two complaints since the previous audit. The two complaints were received via the DHB. Actions were taken as required through to an agreed solution. All complaints are documented and completed within the required timeframes specified in the Code. Action plans sampled confirmed any required follow up and improvements have been made where possible. There is one coroner's case in 2016 which is still pending an outcome and therefore is effectively not closed out.</p> <p>All residents and family members interviewed confirmed being aware of the complaints process. The residents and family identified they were happy with the services provided.</p> <p>The manager is responsible for complaints management and follow up. All staff interviewed reported a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>A family member interviewed stated that the family was kept well informed about any changes in their relative's health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the residents' records sampled. There was evidence of</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>resident/family input into the care planning process.</p> <p>Staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirement of the Code of Health and Disability Services Consumers` Rights (the Code).</p> <p>Interpreter services are available through the DHB when required. Staff knew how to access this service although reported this was rarely required due to staff being able to provide interpretation as and when needed.</p> <p>Family/whanau were available if required for those residents where English is their second language.</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>Karetu House has a documented mission statement and philosophy on care that is focused around the provision of individualised resident focused care that maximises independence. The manager monitors the progress in achieving these goals via the internal audit process and review of resident and family satisfaction at review meetings. A number of goals/objectives are set for the forthcoming year and these are monitored and documented once completed.</p> <p>The day to day operations and ensuring the wellbeing of residents is the responsibility of the registered nurse (RN) who reports to the manager. The manager has managed this rest home for 22 years and has completed approved education in age related care and management to meet the provider`s contract with the district health board (DHB). The manager interviewed has a health and mental health background. The manager is supported by an experienced registered nurse who has worked at this facility for two years. The registered nurse works Monday to Friday and is responsible for the clinical services provided. The three registered nurses have current and valid annual practising certificates which were sighted.</p> <p>On the day of audit there were 43 rest home level residents. The service provider has three contracts with the DHB. Younger persons disabled (YPD) one resident, aged residential care (ARC) rest home (33) and long term chronic (LTC) nine residents. Interviews with residents and a family member confirmed their needs were met by the service.</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</p>	<p>FA</p>	<p>There is a documented quality and risk management system which is understood and implemented by service providers as confirmed during interviews.</p> <p>Policies and procedures are available to guide staff practice. The policies are developed by the manager. Any changes in policy are discussed at staff meetings as verified by staff interviewed and is referenced in applicable meeting minutes. Document control processes are set up and implemented. Policies are current and up to date.</p> <p>A review of the quality and risk programme is undertaken every two months via the review meetings. The staff meeting includes quality management, health and safety, infection control and incident/accident management. The meetings have a set agenda. All key components of service delivery are included and are reported to the quality meeting. The meeting covers complaints and compliments, changes to any policies/practices, the results of any</p>

<p>continuous quality improvement principles.</p>		<p>audits, staffing and education. Restraint minimisation is discussed. The manager has an `open door` to staff and residents/families.</p> <p>Internal audits have been undertaken and are conducted using a template audit form. A schedule sighted details the audits to be undertaken and when. Audits sampled identified compliance by staff in meeting the requirements of the organisation`s policy and the audit criteria. Where improvements were required these improvements have been documented, implemented and monitored. Legislative requirements are met and references used in policies are documented. Obsolete documents are archived.</p> <p>An annual family survey in 2017 was sent out to families/whanau and only one replied. The manager interview stated that many residents do not have any contactable family/friends due to the nature of this service. Residents meetings are held every two months. Minutes sighted reflected discussion on food, the activities programme, staff and the laundry service. Resident compliments were recorded and communicated to staff. Education has been provided to residents on infection prevention and control topics during the resident meetings.</p> <p>A risk management plan is in place. Organisation risks are categorised and documented and mitigation strategies noted. The manager and the RN were able to discuss changes in organisational risk. Staff confirmed that they report any new hazards and the hazard register reviewed was up to date.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow-up actions required. Incident and accident forms are completed by all staff and given to the manager. The incident and accident forms are not signed off as completed until the manager is sure all corrective actions are identified and evaluated. The incident form includes an area to record that family were informed and who else was notified about the reported event (e.g. where applicable the RN and the resident`s general practitioner). A review of a near miss incident and other incidents demonstrated that incident forms are appropriately completed, investigated and responded to in a timely manner.</p> <p>Changes were made to the resident`s care plan where applicable or a short-term care plan developed. Staff communicated incidents and events to oncoming staff via the shift handover. Individual events are discussed with staff every two months at the staff/quality meetings. Any themes or trends over time are monitored and evaluated.</p> <p>The manager was able to identify the type of events that must be reported to external agencies. The manager gave examples of when essential notifications were made to HealthCERT since the last audit. Copies were retained as part of the quality management process.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>The copy of the annual practising certificates (APCs) for the registered nurses, the general practitioner (GP), the contracted pharmacy and the pharmacists involved and a podiatrist were reviewed and all annual practising</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>certificates were current.</p> <p>The recruitment/employment policy aligns with current accepted practices. This includes staff completing an application form and completing a health declaration, police vetting, interviews being conducted and reference checks being obtained and retained. Staff have a signed individual employment agreement and confidentiality/privacy agreement on file. Performance appraisals are conducted at least annually and these were sighted in the relevant staff records sampled.</p> <p>Records evidencing completion of the orientation programme were present in the staff records. Staff interviewed reported orientation included being buddied with a senior staff member. The orientation included the facility, policy/processes, facility routines, staff tasks and the individual resident's care needs.</p> <p>Individual records of education are maintained by the manager for each staff member and copies of education certificates are present in the staff records reviewed. All caregivers are level three with two staff currently completing level four and two staff completing level two. There is one level four diversional therapist. The levels are completed as part of the Careerforce New Zealand Quality Authority aged care related qualifications. In-service education and attendance records were sighted showing staff had access to regular ongoing education relevant to their roles and the service provided. The education planner 2018 was available. Staff education includes all mandatory district health board (DHB) requirements.</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>A policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider's contract with the DHB.</p> <p>The current roster and three weeks of rosters reviewed demonstrated that there is at least one senior caregiver on each shift. The senior registered nurse covers 8am to 5pm five days a week (week days). A registered nurse covers the weekend. The manager covers Monday to Friday and meets with the owner/director weekly. Any gaps in the roster are replaced. The manager ensures any maintenance is attended to and/or arranged with the maintenance person as needed.</p> <p>There is an after-hours service with the registered nurse covering all clinical issues and the manager covers behavioural and staff issues. The contracted general practitioner was interviewed and is also on-call twenty-four hours a day, seven days per week.</p> <p>Additional staff are rostered for the activities programme and the food service. Staff complete the cleaning and the laundry. All caregivers interviewed reported that there is adequate staff available and that they are able to get through their work. The staff confirmed the RN and the manager are available out of hours if required. All staff members have a current first aid certificate and these were sighted.</p> <p>Residents and family members interviewed confirmed staffing meets their needs.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There is a medicine management system implemented to manage safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation that complies with current legislation and safe practice guidelines. The GP reviews the medication charts three monthly and sampled charts had current reviews. Allergies and sensitivities are documented on the medication prescription charts and photos are current. Short-term medication is signed off by the GP when completed. All staff who administer medication have current medication administration competencies. Medication administration competencies for the caregivers are completed by the RN. Current medication competency forms were sighted in sampled files.</p> <p>The RN is responsible for conducting annual medication administration training for the caregivers. Documentation of training records were sighted. The RN is responsible for medication reconciliation when medication is received from the pharmacy monthly and when residents are admitted from the community or other health service providers. There are controlled drugs onsite and weekly and six-monthly stock takes are completed. Documentation of evaluation of effectiveness of 'as required' medication was sighted. Medication is stored safely in locked cupboards.</p> <p>There is a policy for medication self-administration with clear guidelines for staff when needed. There were no residents who were self-administering medication on the day of the audit. Two caregivers were observed administering medication correctly in a manner that complies with safe medicine management guidelines. Previous audit corrective actions have been completed and signed off by the DHB.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food services are provided on site. Food, fluid and nutritional needs of residents are provided in line with nutritional guidelines appropriate to the residents. The food plan is with the city council and a food safety audit was conducted in April 2018. All corrective actions were put in place following the audit and the service obtained a Grade A for food safety. There is a four-week cycle menu in use and this has been reviewed by the dietician. A menu audit and food satisfaction survey were completed in May 2018. Residents are encouraged to give their feedback on meal concerns in the residents' meetings and appropriate follow up is conducted. The cook has a food handling qualification. Safe food handling training for all staff was completed in May 2018 by an external provider.</p> <p>A diet profile with residents' food preferences, food allergies, likes and dislikes is completed on residents' admission and a copy is provided to the kitchen staff. Special diets are provided when required. Interviewed residents reported satisfaction with the food provided. Residents are offered alternative food choices when needed.</p> <p>The kitchen was observed to be clean on the audit day. The pantry was clean and well packed with no food packages on the floor. There was no expired food in stock. There is a food procurement process in place managed by the manager in consultation with the cook. Food, fridge and freezer temperature monitoring records were sighted, Leftover food in the fridge was covered and dated. Monthly weight monitoring for residents is completed and any weight issues are addressed with the involvement of the kitchen staff.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The care plans sampled describe the support required and adequate interventions to manage the identified needs and to achieve the desired outcomes. The care plans are individualised and there is service integration. Documentation from the nursing team, the GP and other external health providers sighted in the sampled files. InterRAI assessment triggered items/outcomes are addressed in the care plans sampled. Previous audit corrective actions have been completed and signed off by the DHB.</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>The service provided is adequate and appropriate to meet residents' assessed needs and goals of support. In the sampled residents' files, evidence was sighted that interventions are consistent and contribute to meet the residents' assessed needs and desired outcomes. Residents are involved in planning their care. Appropriate links are developed and maintained with other services and organisations working with the residents. Interviewed residents and family/whanau reported satisfaction with the services provided.</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>	FA	<p>Activities are planned in consultation with the residents and are provided/facilitated to develop and maintain residents' skills and interests that are meaningful to the residents. There are planned activities for the residents over 65 years of age and for the under 65 years. The activities coordinator has diversional therapy training level four. Residents' activity plans are completed by the activities coordinator on admission with input from the resident and/or their family /whanau where appropriate. A resident survey for activities program is conducted six-monthly. Results are collected and analysed and changes are made when required. The survey results are discussed in staff meetings, meeting minutes sighted. Monthly residents' meetings are held and residents are encouraged to give feedback on the activities program.</p> <p>Residents under 65 years of age actively participate in leading some activities as a way of maintaining their skills. There are volunteers from the local school who help weekly with activities. The residents have access to community events and there is a weekly bus ride. The activities program has a wide range of activities and is posted on the notice board weekly. In interview, the activities coordinator reported that one on one activities are provided as required. Residents' activities participation is recorded on the attendance form daily and documented in the progress notes. A log book was sighted for bus outings. Interviewed residents reported satisfaction with the activities program.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Residents, family/whanau if appropriate, RN, caregivers and the manager are involved in evaluation of the activities plans. The activities coordinator reviews the residents' activity plans six-monthly and earlier when indicated by the resident's change in participation. Where the desired outcome is not achieved, changes are implemented in the activities plan to meet the residents' needs. Documentation of the changes sighted in the sampled files. Interviewed residents confirmed that they are consulted in the review process. Previous audit corrective actions have been completed and signed off by the DHB.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	There is a current building warrant of fitness (BWOFF). Expiry noted to be 15 June 2018. The manager explained that the checks had been completed and the manager was awaiting a new copy of the BWOFF to display. Ongoing checks to maintain the BWOFF are occurring. An external company undertakes performance monitoring and electric safety checking (where applicable) of clinical equipment.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	There is an approved fire evacuation plan and there have been no changes to the facility.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p>	FA	The infection control surveillance undertaken is appropriate to the size and complexity of the service as determined by the infection control committee. Monthly infection statistics are collected, collated and analysed by the infection control coordinator. Any infection trends and statistics are discussed with staff in staff meetings and recommendations to assist in infection control reduction and prevention or interventions are put in place, acted upon and evaluated in a timely manner. Standardised definitions are used for the identification and classification of infection events and indicators. Hand hygiene audits are completed annually, audit reports were sighted. Expert

<p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>advice is sought per rising need through the GP or the local district health board. Referral documents were sighted in the sampled residents' files. Staff were observed using appropriate hand hygiene practices that comply with infection control legislative requirements. An annual infection control report was completed and information gathered was acted upon and used as a basis for formulating infection control goals for this year.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint is used as a last resort after all other options have been trialled. The restraint policy clearly states that the use of enablers shall be voluntary. Interviewed staff demonstrated awareness of the restraint minimisation guidelines. There is a robust restraint assessment and approval process in place involving the restraint coordinator, family/whanau, the resident and the GP. Annual restraint minimisation and safe use training is conducted by the restraint coordinator including challenging behaviour management training. Interviewed staff demonstrated awareness of alternative methods that can be used to manage behaviours that challenge. There were no residents using restraint/enablers on the day of the audit.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.