

# T M & D L Beer Holdings Limited - Kenwyn Rest Home & Hospital

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	TM & DL Beer Holdings Limited
<b>Premises audited:</b>	Kenwyn Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 12 December 2018    End date: 12 December 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	49

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Kenwyn Rest Home and Hospital is privately owned and operated. The service provides care for up to 59 residents requiring hospital, rest home and dementia level care. On the day of the audit, there were 49 residents.

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

The service is overseen by a clinical operations manager/registered nurse who has been in a leadership role at the facility for seven years. The clinical operations manager is supported by a general manager. Residents, family and the GP interviewed spoke positively about the service provided.

The service has addressed all five of the previous shortfalls identified at the previous audit around: interventions, monitoring, self-medicating, chemical safety and maintenance. This audit identified no further areas for improvement.

## 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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Residents and family report communication with management and staff is open and transparent. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The clinical operations manager (COM)/registered nurse and the general manager are responsible for the day-to-day operations of the care facility. The COM reports to the general manager who is on-site for two days a week. The quality and risk management processes are implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. The health and safety programme meet current legislative requirements. Adverse, unplanned and untoward events are documented and investigated. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## 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.

Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate. Care plans are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner or nurse practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

## 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.

The building has a current warrant of fitness. Reactive and preventative maintenance occurs.

## 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.

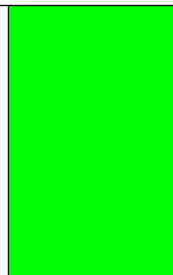


Standards applicable to this service fully attained.

The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There are four restraint and two enablers in use.

## 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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	18	0	0	0	0	0
<b>Criteria</b>	0	45	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. A register of all complaints received is maintained. Three complaints were received between the period November 2017 and December 2018. Documentation including follow-up letters and resolution demonstrated that complaints are well-managed.</p> <p>Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Service information is provided to all residents and family on entry to services. There is also specific dementia unit information provided as needed. The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed always. The policy also describes that open disclosure is part of everyday practice. Six caregivers and an RN interviewed understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Three hospital level relatives and two from the dementia unit interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. A family communication sheet is held in the front of the residents' files. One hospital and one rest home level resident interviewed agreed that they are</p>



<p>conducive to effective communication.</p>		<p>informed and that the managers are available.</p> <p>The clinical operations manager reports that the family is contacted a minimum of monthly to update them on the resident's health status. Ten accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the citizens' advice bureau. Families and staff are utilised in the first instance.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Kenwyn Rest Home provides care for up to 59 residents at rest home, hospital (geriatric and medical) and dementia level of care. The dementia unit provides care for up to 19 residents. The rest home and hospital has 40 beds (8 dual-purpose, 12 hospital and the remaining rest home level). On the day of the audit, there were 14 residents in the dementia unit, 17 hospital residents and 18 rest home residents. One resident was receiving palliative care (hospital) and the balance were on the aged residential care contract.</p> <p>An annual business plan has been developed that includes a philosophy, values and measurable goals. Business goals documented for 2017 have been reviewed and summarised and a 2018 business plan developed.</p> <p>An experienced COM manages the service. She is a registered nurse (RN) with 24 years of nursing experience in aged care and has been in a leadership role at this facility for the past 7 years. She receives support from a general manager with a business background and a team of care staff that includes five RNs and an enrolled nurse. She is on-site three and a half days a week and the general manager is on-site two days a week. Both managers are also responsible for operations at another aged care facility.</p> <p>Both managers have completed at least eight hours of training related to management of an aged care facility, relevant to their role and responsibilities.</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</p>	<p>FA</p>	<p>A quality and risk management programme is in place. Interviews with the general manager, clinical operations manager, care staff, one cook, one maintenance, one diversional therapist and activities coordinator reflected their understanding of the quality and risk management system.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to interRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies.</p> <p>Quality data collected is collated and analysed using a run chart methodology. Quality data is regularly</p>

<p>improvement principles.</p>		<p>communicated to staff via monthly staff meetings and through the use of graphs that are posted each month in the staff room.</p> <p>An internal audit programme is implemented. Areas of non-compliance include the initiation of a corrective action plan with corrective actions signed off to evidence their implementation. There was evidence in the monthly staff meetings to verify staff are informed of audit results and corrective actions. A quality improvement register is maintained that keeps a running tally of quality initiatives. Examples since the last audit included (but were not limited to): RNs and the clinical operations manager meeting monthly to look at 'how they can do better – thinking forward' and innovative changes to the in-service education programme.</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (clinical operations manager) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed.</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>An accidents and incidents reporting policy is in place. Adverse events are linked to the quality and risk management programme. There was evidence to support actions to minimise the number of incidents. Clinical evaluation of residents following an adverse event is conducted by a registered nurse and was evidenced in all ten accident/incident forms selected for review.</p> <p>Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events.</p> <p>The clinical operations manager is aware of the requirement to notify relevant authorities in relation to essential notifications. There had been no notifications since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>FA</p>	<p>There are human resources management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity, evidenced in seven staff files randomly selected for review (two caregivers, one registered nurse, one cleaner, one cook, one maintenance person and the clinical operations manager/facility manager).</p> <p>Copies of practising certificates are kept on file. The service has an orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted in all</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>seven files. Annual staff appraisals were up to date.</p> <p>An in-service education programme is implemented. Regular in-services are provided by a range of in-house and external speakers including (but not limited to): equipment providers, Aged Concern and the Health and Disability Advocacy Service. Webinars had been used to cover a number of infection control topics.</p> <p>Caregivers and activity staff who work regularly in the dementia unit have completed their New Zealand Qualification Authority (NZQA) approved dementia qualification. Innovations had been made in the education programme with six caregivers with Level four qualifications delivering education sessions to their fellow workers which added interest to education.</p> <p>There are three RNs interRAI competent.</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>Policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. A clinical operations manager is on-site three and a half days a week.</p> <p>The rest home/hospital (eighteen rest home and seventeen hospital residents) is staffed with one RN each shift. A second RN is on-site two days a week (when the clinical operations manager is unavailable). The dementia unit (14 residents) is overseen by the RN covering the rest home/hospital.</p> <p>There are adequate numbers of caregivers in the dementia unit and rest home/hospital. The night shift is staffed with two caregivers in the rest home/hospital (plus the RN) and one caregiver in the dementia unit. Extra staff can be called on for increased resident requirements.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: 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>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual electronic medication orders with photo identification and allergy status documented. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy.</p> <p>Short-life medications (i.e., eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Administration sheets sampled were appropriately signed. Ten medication charts reviewed identified that the GP/NP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. One resident self-administer medicines and has a current</p>

		<p>competency assessment around this. They have access to secure storage in their rooms. Staff check each shift that these residents have safely self-administered their medications and record this on the medication administration sheet. This is an improvement from the previous audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals at Kenwyn Rest Home are prepared and cooked on-site. There is a food services manual in place to guide staff. The verified food safety plan expires 6 April 2019. There is a four-weekly seasonal menu. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RN. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met. Snacks are available to residents in the dementia unit.</p> <p>Meals are plated and served from the kitchen to the rest home and hospital residents in the dining room and to the residents in the dementia unit. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. The dishwasher is checked regularly by the chemical supplier. All staff who work in the kitchen have completed or are currently completing their food safety course.</p> <p>There are specialised crockery such as lip plates, mugs and utensils to promote resident independence with meals.</p> <p>Residents have the opportunity to provide feedback on the menu and food services through the resident meeting and resident surveys. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes.</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 long-term care plans reviewed described the support required to meet the resident's goals and needs. Interventions were documented in sufficient detail to meet the residents' needs. Care plans reviewed included: the care of an indwelling catheter; management of a resident with insulin; a resident with MRSA; restraint management; and skin care, all of which were documented well. This is an improvement from the previous audit. The management of behaviours that challenge, triggers and managing a calm environment were documented in the two resident files reviewed from the dementia unit.</p> <p>The care plans sampled identified allied health involvement. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. The service uses the interRAI care plan template. Staff interviewed reported they found the plans easy to follow.</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>	<p>FA</p>	<p>Care plans sampled were goal orientated. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary.</p> <p>There were five residents with six wounds at the time of the audit. There were no identified pressure injuries. Assessments, management plans and documented reviews were in place for all wounds.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available as required to assist with mobility assessments and the exercise programme.</p> <p>Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed. This is an improvement from the previous audit.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities team is led by a diversional therapist and three activities coordinators. The programme operates five days a week 7 days in the dementia unit. There is a separate programme for residents in the dementia unit. Each resident has an individual activities assessment on admission, which is incorporated into the interRAI assessment process. An individual activities plan is developed for each resident by the activities coordinators, in consultation with the registered nurses. There is a 24-hour activity plan documented for residents in the dementia unit. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All long-term resident files sampled have a recent activity plan within the care plan and this is reviewed at least six-monthly when the care plan is evaluated, or a further interRAI assessment occurs.</p> <p>Residents and families interviewed commented positively on the activity programme.</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>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and rewritten or updated. There was documented evidence that care plan evaluations were current in resident files sampled. The files sampled documented that the GP or NP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise, or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility including the dementia unit. This is an improvement from the previous audit. Safety data sheets are available.</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>The building has a current building warrant of fitness which expires April 2019. There is a maintenance person employed 20 hours per week to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>A number of outstanding maintenance issues were noted during the previous audit. These have all been addressed. They include addressing the showers in the dementia unit; the floor under the commercial washing machine; flaky paint on the ceiling above the commercial dish washer in the kitchen; the cupboards in the dementia unit; the bench under the hand basin in room 78; chipped paint in various areas; dirty carpets; and a malodour in the dementia unit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in Kenwyn's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at all staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical operations manager. There have been no outbreaks since the last audit.</p>

<p>been specified in the infection control programme.</p>		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers. Four residents have a restraint (bedsides as a restraint and one resident was using a lap belt) and two enablers were in use. An assessment was completed, and written consent was provided by the resident for the use of enablers. Long-term care plans reflected their use, care interventions and the risks.</p> <p>Staff interviews confirmed their understanding of the differences between a restraint and an enabler.</p> <p>Staff receive regular training around restraint minimisation that begins during their induction to the service. A restraint competency questionnaire is completed by staff each year.</p>

## Specific results for criterion where corrective actions are required

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

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

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

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

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

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

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

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End of the report.