

Presbyterian Support Central - Cashmere Hospital (16 & 51 Helston road)

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Presbyterian Support Central
Premises audited:	Cashmere Hospital (51 Helston Road) Cashmere Hospital (16 Helston Road)
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 October 2017 End date: 20 October 2017
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:	61



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

PSC Cashmere is part of the Presbyterian Support Central organisation and provides rest home and hospital (geriatric and medical) level care at two sites – Cashmere Home and Cashmere Heights. These two sites are separated by a four-minute walk between each other. On the day of the audit, there were 61 residents (36 at Cashmere Home and 25 at Cashmere Heights).

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

The service is overseen by a facility manager, who is a registered nurse and well qualified and experienced for the role. The facility manager is supported by a regional manager and two clinical coordinators. Residents and the GP interviewed spoke positively about the service provided.

The service has addressed the one shortfall from the previous certification audit around completing wound assessments.

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.
--	--	--

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

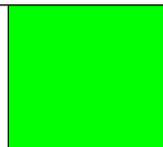
Organisational management

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.
---	--	--

PSC Cashmere is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including fortnightly senior team meetings. Quality performance is reported across various meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The orientation programme provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

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.

At both Cashmere Home and Cashmere Heights the registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed in resident records demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals.

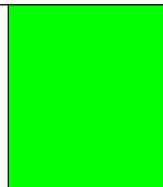
The recreational team provide an activities programme at each site for the residents that is varied, interesting and involves the families/whānau and community.

Medication policies comply with legislative requirements and guidelines. Registered nurses administer medications with some senior caregivers checking medicines. All responsible in the medication process complete education and annual medication competencies.

All meals are prepared at Cashmere Home. Food is transported along the road in a van for Cashmere Heights. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents and family/whānau interviewed were complimentary about the food that was provided.

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.

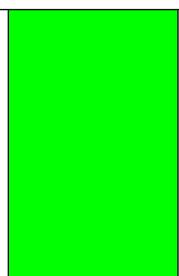
A current building warrant of fitness is displayed for each facility.

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.
---	---	--

PSC Cashmere has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were four residents with restraint and ten residents with an enabler.

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 surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	40	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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>There is a complaints policy to guide practice and this is communicated to residents and family. The facility manager leads the investigation and management of complaints. There is a complaint's register that records activity. Complaint forms are visible around both facilities (Cashmere Home and Cashmere Heights).</p> <p>There have been three complaints lodged at Cashmere Home (year to date) and no complaints lodged at Cashmere Heights. Follow-up letters, investigation and outcomes were documented in all three instances. Timeframes for responding to complaints meet Health and Disability Commissioner (HDC) guidelines.</p> <p>Discussions with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	FA	<p>There is an open disclosure policy. Twelve residents interviewed (Cashmere Home: five hospital, two rest home; Cashmere Heights: five rest home) stated they were welcomed on entry and were given time and explanation about the services and procedures.</p> <p>Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Fifteen incident forms reviewed (seven from Cashmere Heights and eight from Cashmere Home) documented family were notified following a resident incident. Interviews with six healthcare assistants (who work across both facilities) acknowledged that family are kept informed. Six relatives</p>

<p>effective communication.</p>		<p>interviewed (four from Cashmere Home (hospital) and two from Cashmere Heights (one rest home, one hospital) confirmed they were notified of any changes in their family member's health status.</p> <p>An interpreter service is available and accessible if required. 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>PSC Cashmere (Cashmere Home and Cashmere Heights) is part of the Presbyterian Support Central organisation (PSC) and provides rest home and hospital (geriatric/medical) level care services across the two facilities. The two facilities are located within a four-minute walk from each other. All residents' rooms at both locations are certified for dual-purpose. Cashmere Home has a 40-bed capacity and occupancy on the day of audit was 36 residents (11 rest home and 25 hospital). Cashmere Heights has a 33-bed capacity and occupancy on the day of audit was 25 residents (16 rest home and 9 hospital). Residents were all under the ARC contract only. There were no respite residents and no residents on the medical component.</p> <p>The facility manager at PSC Cashmere is a registered nurse (RN) with over 30 years of aged care experience and has been in the role for six years. She is leaving her position. A suitable replacement has been employed. This individual was beginning her employment as facility manager the following week. She is an RN with a business management degree and holds 16 years of management experience in the aged care sector. The facility manager reported that HealthCert has been informed of this change via a section 31 notification form. The facility manager manages both facilities and is supported by two (full-time) clinical coordinators/RNs, one for Cashmere Home and one for Cashmere Heights.</p> <p>PSC has a mission and vision statement defined. PSC Cashmere has a 2016 – 2017 quality plan and risk management plan that includes specific and measurable goals. The implementation of the Eden philosophy at both facilities has been instrumental in placing the resident as the focus of all events, interventions and decisions.</p> <p>The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.</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</p>	<p>FA</p>	<p>PSC has an overall quality management system in place that is overseen by the head office. Sixteen staff interviews (facility manager, two clinical coordinators (one from each facility), six healthcare assistants (HCAs) (three from each facility), four RNs (two from each facility), one chef and two activities coordinators (one from each facility) confirmed their understanding of the quality and risk management systems that are being implemented. Of particular mention throughout the interview process is the staff's understanding and commitment to the Eden philosophy of residents' cares.</p> <p>Policies and procedures provide assurance that PSC Cashmere is meeting accepted good practice and</p>

<p>quality improvement principles.</p>		<p>adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. There is a PSC organisation policy review group that has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office.</p> <p>The senior team meeting acts as the quality committee and they meet twice a month (combined staff from both sites). Information is fed back to the monthly clinical focused meetings (combined meeting) and staff meetings (separate per site). A range of other meetings are held at the facilities. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms are being signed off and reviewed for effectiveness. Progress with the quality programme/goals is being monitored and reviewed through the monthly senior team meetings.</p> <p>There is an internal audit calendar in place and the schedule is adhered and followed for 2017 (year to date). This internal audit programme is being completed at each facility. Corrective actions are documented when internal audits score less than 85% and the audit is repeated monthly until an acceptable threshold is reached. The facility manager signs off on all corrective actions at both sites. Clinical indicator data is analysed and evaluated. This includes (but is not limited to) falls, infections, pressure injuries, skin tears, bruises, and challenging behaviours. Residents' falls have remained low at both facilities since the previous certification audit.</p> <p>The service has a health and safety management system that meets current health and safety legislative requirements. The health and safety officer was interviewed (clinical coordinator from Cashmere Heights). She is supported by a team of health and safety representatives from both locations. Health and safety meetings include identification of hazards and accident/incident reporting and trends.</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>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information.</p> <p>Fifteen incident forms were reviewed across both facilities (seven from Cashmere Home and eight from Cashmere Heights). All identified follow-up assessments by a registered nurse. Neurological observations are completed by an RN if there is a suspected injury to the head.</p> <p>Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided. There was no evidence of any infectious outbreaks, coroner's inquests or complaints lodged with HDC.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity.</p> <p>Six staff files were reviewed (one staff RN and five HCAs). All but two HCAs work across both locations. All six files included evidence of the recruitment process including reference checking, signed employment contracts and job descriptions, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice that is specific to the job role. Staff interviewed stated that new staff were adequately orientated to the service.</p> <p>Current annual practising certificates were sighted for the health professionals (RNs, physiotherapist, GP, dietitian). A staff education and training programme is implemented that exceeds eight hours annually. Staff are rostered to attend, and attendance is monitored. In addition to PSC study days, RNs attend external sessions provided by the community (e.g., DHB and hospice).</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support. The service runs as two separate facilities and some staff work over both sites. There is at least one registered nurse on duty at all times at each facility. Each facility has a mixture of healthcare assistants working short and long shifts. During weekdays there is a facility manager who oversees both facilities and a clinical coordinator/RN (one at each facility). The facility manager provides managerial oversight for both facilities. Her office is located at Cashmere Home, but she visits Cashmere Heights a minimum of daily.</p> <p>In addition to the clinical coordinator at Cashmere Home (11 rest home, 25 hospital) there are two RNs on the AM shift, and one RN on the PM and night shift. Adequate numbers of HCAs are rostered. Activities are provided seven days a week.</p> <p>In addition to the clinical coordinator at Cashmere Heights (16 rest home, 9 hospital) there is one RN on the AM shift, one RN on the PM shift and one RN on the night shift. The RNs are supported by adequate numbers of HCAs. Plans are underway to use Cashmere Heights for rest home level residents only. The managers (facility manager and regional manager) are aware of staffing requirements for rest home only and confirmed that this change will not impact RN staffing levels at Cashmere Home.</p> <p>There are separate and designated staff for kitchen, laundry, and cleaning. Residents and relatives interviewed advised that there are sufficient staff on duty at any one time and that staff are prompt to answer call bells and attend to residents' 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>Twenty medication files were reviewed (10 at each – Cashmere Home and Cashmere Heights with a mix of rest home and hospital residents at each). There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed were able to describe their role in regard to medicine administration. Standing orders are not used for patients of the house GP. The orders had been reviewed. There were no residents self-medicating on the day of audit.</p> <p>An electronic charting system was used, and all medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly.</p> <p>The medication fridge temperatures are recorded regularly, and these are within acceptable ranges.</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>All meals for Cashmere Heights and Cashmere Home are prepared and cooked at Cashmere Home with the exception of breakfast for Cashmere Heights, which is prepared on-site at Cashmere Heights. The food is placed in bain marie dishes and into hot boxes, which are then transported in the site van. The dishes are then placed in a bain marie from which serving takes place. There is a five-weekly seasonal menu forwarded to the site from the Enliven office, which had been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. Temperatures of meals before serving are recorded weekly and meat temperatures are recorded daily.</p> <p>The food service is managed by a qualified chef, supported by two further chefs and kitchenhands. All food service staff have completed training in food safety and hygiene and chemical safety except for two newly appointed staff who are still completing.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and</p>	<p>FA</p>	<p>Nine of ten residents' files sampled (two rest home and three hospital at Cashmere Home, three rest home and two hospital at Cashmere Heights had a current LTCF interRAI assessment (one resident was new to the service). All assessment tools completed informed the development of the long-term care plan. Wound</p>

<p>preferences are gathered and recorded in a timely manner.</p>		<p>management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP, dietitian and specialist involvement in wounds/pressure injuries. All wounds had an initial assessment and follow-up plan and ongoing evaluation. This previous finding has been addressed.</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>When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation. The family members confirmed on interview they are notified of any changes to their relative's health.</p> <p>In the residents' files reviewed, short-term care plans were commenced with a change in health condition and linked to the long-term support plan. Short-term care plans were viewed for infections, wound, pain and behaviour.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a recreation officer for Cashmere Heights (CH) and another for Cashmere Home (C Home). There is a van (with hoist) shared between the two with a volunteer driver taking a trip out for each, weekly. Individual and group activities are run seven days per week at CH and C Home for the rest home level and hospital level residents that are at each unit. The recreation programme is supported by part-time staff and volunteers. The recreational programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. There are regular outings/drives, inter-home visits for all residents (as appropriate) and involvement in community events. One-on-one activity occurs for residents who are unable or choose not to be involved in activities.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). Of ten files reviewed two residents admitted the week of audit were to have an activities assessment completed and a plan documented. The balance of files reviewed had a documented recreational plan and the plans had been reviewed six-monthly at the same time as the care plans were reviewed. Activity participation was noted in the progress notes.</p> <p>The service receives feedback and suggestions for the programme through surveys, one-on-one feedback from residents (as appropriate) and families and from the resident/relative meetings held by the chaplain three-monthly.</p> <p>Relatives and residents stated they were satisfied with the activities provided.</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>In the residents' files reviewed, all initial care plans were documented and evaluated by the RN within three weeks of admission. Long-term care plans reviewed had been evaluated at least six-monthly or earlier for any health changes. The GP reviews the residents at least three-monthly or earlier if required. Evidence of three-monthly GP reviews were seen in all residents' files sampled apart from the new admissions. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes.</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>A current building warrant of fitness is posted in a visible location at each facility (expiry dates 23 December 2017).</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 control programme.</p>	<p>FA</p>	<p>Policies and procedures document infection prevention and control surveillance methods. Systems are in place and are appropriate to the size and complexity of each facility. The surveillance data is collected and entered into the Enliven GOSH database and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified, and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>There have been no outbreaks at either Cashmere Heights or Cashmere Home since the previous audit.</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>The service has documented systems in place to ensure the use of restraint is actively minimised. The restraint coordinator is the clinical coordinator from Cashmere Heights.</p> <p>There were four residents with restraint (three from Cashmere Home and one from Cashmere Heights) and ten residents with an enabler (bedrails, lap belts). Six were from Cashmere Home and four from Cashmere Heights. Two residents' file where an enabler was in use were selected for review (one from Cashmere Home and one from Cashmere Heights). All required documentation has been completed in relation to enablers.</p> <p>Staff interviews, and staff training records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</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.