

Presbyterian Support Southland - Resthaven Village

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 Southland
Premises audited:	Resthaven Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 26 January 2017 End date: 26 January 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:	56

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

Resthaven is part of the Presbyterian Support Southland (PSS) service. The service provides rest home, hospital (medical and geriatric), and dementia level care services for up to 60 residents. On the day of audit there were 56 residents.

Presbyterian Support Southland has an organisational structure that supports the continuity of management and quality of care and support. The Resthaven nurse manager has been in the role for four years. She is supported by a clinical manager, registered nurses, care staff and PSS management team, including a quality manager and the director of services for older people.

One of the three shortfalls identified at the previous audit has been addressed around timeliness of care and documentation. Improvement continues to be required around care planning and evaluations. This surveillance audit identified further improvements required around wound assessments and documentation and regular registered nurse 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.
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Full information is provided at entry to residents and family/whānau. The rights of the residents and/or their family to make a complaint is understood, respected and upheld by the service. 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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Services are planned, coordinated and are appropriate to the needs of the residents. The nurse manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses are responsible for care plan documentation and this process is overseen by the clinical manager. InterRAI assessments were completed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and families advised satisfaction with the activities programme. The service uses an electronic medication management system. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint minimisation and safe practice policy that is applicable to the service. There are currently five residents using restraint and one resident using an enabler at Resthaven. The enabler consent is in place for the resident using an enabler. Restraint/enabler and challenging behaviour training has been provided.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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PSS Resthaven continues to implement their infection surveillance programme. Infection control issues were discussed at both the infection control and quality/staff meetings. The infection control programme is linked with the quality programme and benchmarked by an international benchmarking service.

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	13	0	1	3	0	0
Criteria	0	36	0	1	3	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 service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. A record of all complaints, both verbal and written is maintained by the nurse manager using a complaints register. Four complaints were made in 2016. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner. Care staff interviewed confirmed that complaints and any required follow-up is discussed at staff meetings. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Full information is provided at entry to residents and family/whānau. Five residents interviewed (one hospital and four rest home) stated that they were welcomed on entry and were given time and explanation about the services and procedures. The nurse manager and clinical manager are both available to residents and families and they promote an open door policy. Incident forms reviewed in January 2017 evidenced that family had been notified on all occasions. Three family (one hospital and two rest home) advised that they are notified of incidents and when residents' health status changes.</p>

communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Resthaven is part of the Presbyterian Support Southland (PSS) organisation. The service is certified to provide hospital (geriatric and medical), rest home and dementia specific care for up to 60 residents. On the day of audit there were 56 residents, 21 hospital residents (including one under the age of 65 and one on an ACC contract), 26 rest home residents (including one under the age of 65) and nine of a potential ten residents in the dementia unit. All rest home and hospital beds are dual-purpose.</p> <p>The nurse manager is a registered nurse and maintains an annual practicing certificate. She has been in the role for four years. The nurse manager is supported by a clinical manager, registered nurses, care staff and PSS management team, including a quality manager and the director of services for older people. Presbyterian Support Southland has an overall strategic plan and quality programme with specific quality initiatives conducted at Resthaven. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The nurse manager has completed in excess of eight hour's professional development in the past 12 months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Resthaven is implementing a quality and risk management system that includes participation in an international benchmarking programme, which includes a collection of quality data. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service has comprehensive policies/ procedures to support service delivery. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p> <p>Quality matters are taken to the monthly quality meetings that comprise a core group of staff. There is a quality manager (RN) for the PSS group who has been with the service since November 2013. The quality manager supports Resthaven in implementing the quality programme. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff.</p> <p>The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Resthaven infection control and health & safety committees both meet monthly. Infections and health and safety matters, such as staff accidents are discussed at the relevant meetings. Information is then taken to the quality meeting and then fed back to the bi-monthly staff meetings. Resident meetings also occur bi-monthly. Relatives interviewed confirm that this is happening. An internal organisational audit programme is in place that includes aspects of clinical care. Areas of non-compliance identified at internal audits are either resolved at the time or developed into a quality improvement plan. The closure of corrective actions resulting from internal audit programme was</p>

		recorded.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects incident and accident data and reports aggregated figures monthly to the quality meeting. Incident forms are completed by staff, the resident is reviewed by the RN at the time of event and the form is forwarded to the manager for final sign off. A sample of fourteen resident related incident reports for January 2017 was reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. Reports were completed and family notified as appropriate. There is an incident reporting policy to guide staff in their responsibility around open disclosure. The caregivers interviewed could discuss the incident reporting process.</p> <p>The nurse manager was familiar with requirements around statutory reporting. Two notifications have been made to HealthCERT regarding pressure injuries.</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>	FA	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Six staff files were reviewed (one clinical manager, one registered nurse (RN), three caregivers and one activities coordinator). All had relevant documentation relating to employment. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>The in-service education programme for 2016 has been completed and a plan for 2017 is being implemented that covers all contractual education topics and exceeds eight hours annually. PSS has a compulsory study day that includes all required education as part of these standards. The nurse manager and registered nurses are able to attend external training including sessions provided by the local DHB. A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed and a record of completion is maintained and signed. Competency questionnaires sighted in reviewed files.</p> <p>There are 19 caregivers who work in the dementia unit. Eighteen have completed the unit standards. One is working towards completion of the unit standard and has commenced work in the last 12 months.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>Presbyterian Support Southland policy includes rationale for staff rostering and skill mix. There is at least one registered nurse to cover the entire facility 24 hours per day. In addition there is either a registered nurse or an enrolled nurse on duty in the rest home area on morning duty. The clinical manager provides nursing cover in</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>the dementia unit (link 1.3.3.4). Advised, that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify 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>Resthaven uses an electronic medication management system. The supplying pharmacy delivers all medicines and these are checked by registered nurses on delivery.</p> <p>Medications are stored securely in two areas (rest home/hospital and dementia unit). Controlled drug medications are appropriately stored. There was one self-medicating resident and appropriate competency assessments had been completed.</p> <p>Medications were checked and signed on arrival from the pharmacy.</p> <p>All 10 electronic medication records sampled showed that guidelines and legislation were met around prescribing and review and that medication had been administered as prescribed. All staff who administer medication (including insulin) have been assessed as competent to do so.</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>The main kitchen supplies meals for the whole facility. All staff working in the kitchen have food safety certificates (NZQA). Food is served from the main kitchen to the dining area adjacent to it. Other dining areas have food transported in a bain-marie to the rest home dining room and individual plates with thermal covers to the dementia unit.</p> <p>Special diets are being catered for. The menu is designed and reviewed by a registered dietitian at an organisational level. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or sooner if required. The kitchen staff were aware of changes in resident's nutritional needs.</p> <p>An annual resident satisfaction survey was completed and showed satisfaction with food services. Regular audits of the kitchen fridge/freezer temperatures and food temperatures were undertaken and documented. Residents and families interviewed reported satisfaction with food choices. Special equipment was available and this was assessed as part of the initial nursing assessment. There are additional nutritious snacks available over 24 hours.</p>
<p>Standard 1.3.5: Planning</p>	<p>PA</p>	<p>All five resident files sampled had care plans that had been reviewed at least six monthly by a registered nurse and were completed using a series of template headings. Caregivers described care plans as easy to follow and</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>Moderate</p>	<p>reported they were informed of specific resident needs at handover. Not all identified needs were addressed in three of the five care plans sampled. This issue was identified at the previous audit and continues to require improvement.</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>PA Moderate</p>	<p>Resident files reviewed showed that consultation and liaison were occurring with other services. Care plan evaluations and reviews were completed at least six monthly but not all identified needs were addressed (link 1.3.5.2) and were not always updated when changes were identified (link 1.3.8.3). The GP interviewed spoke positively about the care provided to residents they oversee at Resthaven. The GPs documentation and records were current.</p> <p>Adequate continence and dressing supplies were sighted on the day of audit. Weights were recorded on a monthly basis, included in the care plan interventions (except for one file sampled – link 1.3.8.3) and were evaluated by the RNs, identifying any resident with issues.</p> <p>Wound assessments of pressure injury wounds were not accurate. Six of eleven minor wounds had an appropriate assessment, plan and review. One resident with surgical wounds had not had appropriate assessments, plans and reviews documented.</p> <p>The registered nurses interviewed described appropriate clinical assessments and monitoring records, including food and fluid and turning charts were accurately documented.</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 are three activities coordinators who provide cover in the rest home and hospital area for six days a week. Activities programmes were modified according to resident's interests and abilities and covered physical, social, recreational and emotional needs of the residents.</p> <p>In the dementia unit the caregiver ratio is high to allow staff time to provide targeted activities with residents. One staff member has additional hours specifically to provide activities. Residents were sighted engaging with staff in a variety of activities during the audit. In the dementia unit, caregivers were involved in the activities over a 24-hour period and have individual activities that can be carried out with residents on a one-on-one basis. Caregivers were observed at various times throughout the day diverting residents from behaviours.</p> <p>The service provides frequent engagement with the community and regular outings including trips out of town. Activities care plans were completed and evaluations were completed when care plan reviews occurred. The activities coordinator interviewed stated that they were well supported in their role by the PSS and they participate in a Southland diversional therapy group. Residents and families interviewed stated satisfaction with activities provided.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Care plans were evaluated six monthly or more frequently when clinically indicated. All initial care plans were evaluated by the RN within three weeks of admission. Care plans were not always updated when the evaluation identified changes in needs.</p> <p>Short-term care plans were evidenced in the sampled files reviewed and had been evaluated. This is an improvement since the previous audit. They were used for infections, wounds, falls and changes in residents' health status.</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>	FA	<p>The service has a building warrant of fitness which expires in 24 June 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>	FA	<p>PSS Resthaven continues to implement their infection surveillance programme. Individual infection report forms were completed for all infections. Infections were included on a monthly register and a monthly report was completed by the infection control coordinator. Infection control (IC) issues were discussed at the various facility meetings. The IC programme is linked with the quality programme and benchmarked by an international benchmarking service.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint minimisation and safe practice policy that is applicable to the service and has recently been updated by the organisation. There are currently five residents using restraint and one resident using an enabler at Resthaven. The enabler consent is in place for the resident using an enabler. The resident's file reviewed had completed documentation relating to assessments, monitoring, risks related to use of enabler and review of enablers. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint/enabler and challenging behaviour training has been provided in May 2016.</p>

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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the	PA Moderate	There are registered nurses on duty at all times in the facility and registered nurse hours are dedicated in the rest home. The clinical nurse manager is intended to provide one hour each morning and one hour each afternoon in the dementia unit but this is not always possible due to other demands. All urgent issues in the rest home and dementia unit are attended to by a registered nurse as reported by the caregivers and the clinical manager. The registered nurses and caregivers document notes in separate parts of the clinical file. Registered nurse notes are not always regular and do not always follow up issues identified in caregiver notes.	The one dementia file sampled and a further two in an extended sample around progress notes identified that issues documented by caregivers were not always followed up by a RN. There was no documented evidence of regular assessment/input from a registered nurse. Two of two hospital files sampled had issues identified by caregivers that had not been followed up by registered nurses.	Ensure that all residents are assessed by a registered nurse regularly and when issues are identified and that this is documented. 60 days

function.				
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>All resident files sampled contained a comprehensive care plan document with a range of template headings. Two of five care plans had interventions described for all identified needs.</p>	<p>Three of five files sampled (one dementia, one rest home and one hospital) had identified needs that had not been addressed in the care plan.</p>	<p>Ensure all identified needs include documented interventions to manage in each resident's care plan.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Six of eleven minor wounds (one leaking oedematous leg in the rest home, two skin tears, one surgical wound, one blister and one gout wound in the hospital) had a comprehensive documented assessment and management plan. These and two pressure injuries (stage-2 for one resident) had appropriate plans and reviews. One resident with three surgical wounds did not have appropriate documentation around the management of these.</p>	<p>(i) Three sets of wound documentation (including one pressure injury) have more than one wound on one page. (ii) Three wounds including one pressure injury have not been well assessed. (iii) The other pressure injury was assessed but incorrectly graded. (iv) One resident with three surgical wounds does not have any assessment, plan or evaluations relating to one wound and the other two surgical wounds have been treated as one wound with the assessment and evaluations combined. (v) Three wounds (two of two from the dementia unit and one from the hospital) have had significant periods when wounds have not been documented as reviewed.</p>	<p>Ensure all wounds have a comprehensive assessment and plan documented and are reviewed within appropriate timeframes.</p> <p>60 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds</p>	<p>PA Low</p>	<p>All care plans had been reviewed regularly and when changes were identified these were documented in the evaluation section of each section of the care plan. However the care plan interventions were not always updated to reflect</p>	<p>Two of two rest home files had changes to needs identified in the evaluation but the care plan had not been updated to reflect this.</p>	<p>Ensure care plans are updated when changes in need are</p>

by initiating changes to the service delivery plan.		these changes.		identified. 90 days
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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.