# Oceania Care Company Limited - Heretaunga Home & 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 Central Region's Technical Advisory Services 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Heretaunga Rest Home & Village

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

**Dates of audit:** Start date: 12 June 2017 End date: 13 June 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:** 24

# 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 |
|  | 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

Heretaunga Rest Home & Village (Oceania Healthcare Limited) can provide care for up to 40 residents. This surveillance audit was conducted against the relevant Health and Disability Services Standards and the service contract with the district health board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

There were no areas identified as requiring improvement from the last certification.

There were areas requiring improvement identified at this audit relating to inclusions on the hazard register.

## Consumer rights

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| 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. |

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service are available and accessible to residents and their families on admission, throughout the facility and through resident meetings.

Residents and family members confirmed their rights are being met, staff are respectful of their needs and that communication is appropriate.

A complaints register is maintained and up to date. The complaints reviewed were investigated, with documentation completed and stored in the complaints folder.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Oceania Healthcare Limited is the governing body and is responsible for the services provided at the facility. A business plan and quality and risk management systems document the scope, direction, goals, values and mission statement of the facility.

There is a quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and monthly reports to the national support office allow for benchmarking and the monitoring of service delivery. Benchmarking reports include clinical indicators, incidents/accidents, infections and complaints, with an internal audit programme implemented. Corrective action plans are documented and there is evidence of resolution of issues when these are identified. There is an electronic database to record risks. Risks and controls are clearly documented.

The facility has an incident and accident management system that records and reports all adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting. Documentation confirmed that staff communicate with residents and family members about incidents.

The business and care manager is responsible for the overall management of the facility. The business and care manager is supported by a clinical manager and the regional and executive management teams. Service delivery is monitored.

Recruitment and employment practices are in line with legislative requirements. All staff and allied health professionals have current practising certificates if they require them.

Staffing levels are adequate across the service with current and implemented human resource policies. Registered nurses are on duty seven days per week and are supported by adequate levels of care and allied health staff.

Staff competency is assessed and a training plan is implemented.

## Continuum of service delivery

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| 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. |

The clinical manager and the registered nurse assess residents on admission. Residents’ needs assessments are completed within the required timeframes.

Person centred care plans are individualised and based on a range of clinical information. Short-term care plans are in place to manage short-term problems. The residents’ records reviewed demonstrated their needs, goals and outcomes are identified and reviewed at regular intervals. Interviews confirmed residents and their families are informed and involved in care planning and evaluation of care. Handovers facilitated continuity of care.

The activity programme is managed by the activities coordinator and reviewed annually by a diversional therapist. The programme provides residents with a variety of individual and group activities, including a 24-hour activities plan for each resident in the dementia unit. These plans guide the management of challenging behaviour. The service uses its facility bus for outings in the community.

Medicines management occurs according to policies and procedure, in alignment with legislative requirements and consistently implemented using an electronic system. Medications are administered by registered nurses and senior healthcare assistants. Medicine management competencies for staff who administer medicines are current.

The food service meets the nutritional and other specific needs of the residents. Staff have food safety qualifications. The kitchen was observed to be clean and meets food safety standards. Residents confirmed satisfaction with meals.

## Safe and appropriate environment

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| 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. |

There is a current building warrant of fitness. The facility is in the process of a re-cladding and refurbishment project with areas being vacated for this purpose. The rooms currently occupied by residents are fit for purpose.

## Restraint minimisation and safe practice

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| 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 restraint minimisation and safe practice policies and procedures define enablers and restraints, and comply with this standard. There were no residents using enablers or restraints at the facility during the on-site audit. Staff interviewed demonstrated an understanding of what constitutes enabler and restraint use. Staff interviews confirmed receiving ongoing restraint and challenging behaviour education.

## Infection prevention and control

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| 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 activities are appropriate to the size and scope of the services.

Infection control management systems are in place to minimise the risk of infection to residents, visitors and staff. Infection data is collated monthly, analysed and reported to Oceania Healthcare Limited support office, management and staff. Results of the surveillance are acted upon, evaluated and reported.

## Summary of attainment

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

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| **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 | 15 | 1 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 1 | 0 | 0 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The organisation’s complaints policy and procedures are in line with the Health and Disability Commissioner’s Code of Health and Disability Services Consumers' Rights (the Code). The complaints process records a summary of the complaints, the investigation, outcome and other processes of complaints management. All complaints reviewed demonstrate resolution and documentation to support closure. It was noted that there were no complaints recorded in the eight months prior to the commencement of the current facility business care manager (BCM). Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint process and the Code. The complaints process is also reaffirmed through resident/family meetings. The complaint process is readily accessible and complaints forms are displayed for easy access. Residents and family interviewed confirmed having an understanding and awareness of these processes. Resident meetings are held two monthly and meeting minutes confirmed that residents and their families are able to raise any issues they have during these meetings. Opportunities for improvement have been implemented as a result of identifying shortfalls through complaints, adverse events monitoring and suggestions from residents. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Information is provided to residents and their families as part of the information admission pack. The resident admission agreement, signed by residents or their representative on entry to the service, details information about the services that are included in service provision. Two monthly resident/family meetings provide information and an opportunity for resident input. Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and families. The residents' files reviewed provided evidence that communication with family members is documented in residents' records. There is evidence of communication with the general practitioner (GP) and family following adverse events. Interpreter services are available if required. Residents in the rest home and family members of residents in the dementia unit, stated they know who the staff are who are responsible for their care and confirmed staff communicate with them in an open and transparent manner. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Oceania Healthcare Limited’s vision, values, mission statement and philosophy are displayed at the entrance to the facility and in information booklets. The organisation records their scope, direction and goals in their business, strategic and quality plans. The facility’s BCM provides monthly reports to the company’s national support office. Business status reports, benchmarked against other Oceania facilities include: quality and risk management issues; occupancy; human resource issues; quality improvements; internal audit outcomes; and clinical indicators. The BCM is supported by a clinical manager (CM), who is responsible for clinical matters, and the regional clinical quality manager. The BCM has been in the role for six months, has a level five diploma in business management and previous experience as a healthcare assistant and as an activities coordinator. The CM is a registered nurse (RN) with a current annual practising certificate and has been in this role for 15 years. The facility can provide support for a maximum of 40 residents with 16 beds identified as rest home and 24 dementia care beds. On the day of the audit there was an occupancy of 24. This was made up of 14 residents requiring rest home level of care and 10 residents requiring dementia level of care. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Negligible | The facility uses the Oceania Healthcare Limited’s (Oceania) documented quality and risk management framework to guide practice. The facility implements organisational policies and procedures to support service delivery. All policies are subject to review and are current. All polices are reviewed by the national support office, with input from BCMs. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced based best practice guidelines. Policies are available to staff in hard copy. New and revised policies are presented to staff at staff meetings. There is a current interRAI policy.A quality improvement plan with quality objectives was reviewed and these are used to guide the quality programme. There is a detailed hazard register that identifies health and safety risks, as well as: risks associated with human resource management; legislative compliance; contractual risks; and clinical risk. However, hazards associated with the recladding project, whilst well mitigated, were not identified on the register. A health and safety manual is available that includes relevant policies and procedures. Service delivery is monitored through: complaints; incidents and accidents; and implementation of an internal audit programme, with corrective action plans documented and evidence of resolution of issues completed. There is documentation that includes: the collection; collation; and identification of trends and analysis of data.There are monthly combined staff, quality, clinical and health and safety meetings. Meeting minutes evidenced communication with staff regarding all aspects of quality improvement and risk management. All meetings have an agenda and minutes are maintained with the identification of people responsible for outcomes and timeframes. Clinical indicators and quality improvement data are recorded and staff are informed at staff meetings.Family/resident and staff satisfaction surveys are completed as part of the annual audit programme. Collated results are compared with previous surveys and actions arising from findings implemented. |
| Standard 1.2.4: Adverse Event Reporting 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.  | FA | The BCM and CM confirmed an understanding and awareness of the circumstances and events that require the facility to report to and notify statutory authorities, including police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks. Times when authorities have had to be notified are documented and retained on the relevant file.Staff records demonstrated staff receive education at orientation on the incident and accident reporting process. Staff interviews confirmed an understanding of the adverse event reporting process and their obligation to documenting all untoward events. The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities.There has been one external complaint since the last audit. It was noted that the facility, although part of the investigation, was not the subject of the complaint or the decision. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Human resource policies and processes are in place and implemented. The two registered nurses (RN) hold current annual practising certificates. Staff files include employment documentation such as: job descriptions; contracts; and appointment documentation on file. Police and drug checks are completed and an annual appraisal process is in place. All staff employed for greater than one year having a current performance appraisal. Newly employed staff have interim appraisals at three and six months after employment.All newly recruited staff have completed an orientation programme. Mandatory training is identified on a company-wide training schedule. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training maintained. The service has a varied approach to ensuring that staff receive annual training that includes attendance at training sessions and annual individualised training around core topics such as: medication; restraint; infection control; health and safety; manual handling and continence. Two registered nurses and the BCM have completed the interRAI assessment training.The training register and training attendance sheets demonstrate staff completion of annual medication and other competencies such as: hoist; moving and handling; hand washing; wound management and two yearly first aid competency. Staff have completed training standards required around dementia care. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy. Rosters were checked to ensure that residents requiring either dementia or rest home level of care were well supported according to individual need. Residents requiring rest home level of care were encouraged to be as independent as possible. The CM provides 24-hour, on-call support for clinical matters.Residents and families confirm that staffing is adequate to meet the residents’ needs. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medicine management system is documented, implemented and complies with legislation, protocols and guidelines. The service uses pharmacy pre-packaged medicine that is checked by the RN on delivery. All reviewed folders evidenced medicines reconciliation documentation. A computer based medication system is used. Weekly checks and six-monthly stocktakes are conducted and confirmed that stock levels were correct. The medication refrigerator temperatures are monitored. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are stored appropriately. Staff members administering medication complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled. There were no residents who self-administered medications during the on-site audit days. The service provider has systems and processes in place should they receive a resident who wanted to self-administer medicines.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The seasonal menu has been reviewed by a dietitian. Resident meals are prepared on site. The cook who is newly employed at the facility confirmed an understanding of the dietary needs of residents. Kitchen staff have current food management handling/food safety certificates. Diets are reviewed and modified. The dietary profiles are communicated to kitchen staff on the resident’s admission to the facility. Residents’ dietary profiles are developed on admission which identify the residents’ daily dietary requirements and preferences. When a resident’s dietary needs change, the kitchen is informed. Nutritional assessments are reviewed six-monthly. Supplements are provided to residents with identified weight loss problems or wound care needs. Food containers are labelled and dated. Decanted food had records of expiry dates documented. Records of temperature monitoring of food, fridge refrigerators and freezers are maintained. Regular cleaning is undertaken. Food services comply with current legislation and guidelines. Interviews with residents and their families confirmed satisfaction with the food service. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents' care plans are based on assessed needs, desired outcomes and goals, as identified through the interRAI assessment and other risk assessments. Person centred care plans are completed by a registered nurse and clinical manager. Plans of care include specific interventions for both long-term and the short-term problems.The GP documentation and records are current. Interviews with residents and families confirmed care and treatments meet their needs. Interviews with staff members confirmed they are familiar with the needs of the residents. Family communication is recorded in the residents’ files. Nursing progress notes and observation charts are maintained. |
| Standard 1.3.7: Planned ActivitiesWhere 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. | FA | The activities programme is developed and implemented by the activities coordinator (AC) with oversight of a local diversional therapist (DT). The residents’ activities assessments are conducted by the AC within the three weeks of the residents’ admission to the facility. Residents’ interests are recorded during an interview with the resident and their family. The activity care plan is part of the long-term care plan and reflects the residents’ preferred activities. The AC participates in the evaluation process. Residents and their families reported satisfaction with the activities provided. Reviewed files of residents with dementia included 24-hour activity plans, with specific interventions identified to manage challenging behaviour.During the on-site audit the residents were observed engaging in a variety of activities and outings. Resident meetings are conducted bi-monthly. Past minutes of residents’ meetings were displayed on notice board for resident and family information. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long-term and the short-term care plans are evaluated in a comprehensive and timely manner. Care plan evaluations include the residents’ degrees of achievement towards meeting the desired goals/outcomes. Residents’ responses to the treatment is documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved.Short-term care plans are developed when needed and record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem was resolved.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building warrant of fitness is current and posted in a visible location at the entrance to the facility, The facility is currently undergoing a full exterior recladding project. This has resulted in rooms being vacated in a staged project as individual sections are recladded and refurbished.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control surveillance policy identifies the requirements around the surveillance of infections. Infection logs are maintained and collated monthly by the infection control nurse (ICN), who is the clinical manager and a registered nurse. Collated infection control data is communicated as clinical indicators to the Oceania support office, management and staff. Interview with the GP confirmed infections are reported in a timely manner. Interviews with staff reported they are made aware of infections through feedback from the RNs, verbal handovers, short-term care plans and progress notes. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint minimisation and safe practice handbook and policies comply with this standard and relevant legislation. The restraint coordinator is the clinical manager. A signed position description was sighted. There were no residents using enablers or restraints during the on-site days of audit. The service has a restraint register should it ever need to be used. Forms are available should an enabler or restraint be required, including assessment; consent; review; and monitoring forms.National data shows there has been significant reduction in restraint use in the organisation. Staff receive restraint and management of challenging behaviour education via the Oceania study days and RN study days. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.9Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;(b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Negligible | The facility had a detailed hazard register. The facility is undergoing a recladding project of the exterior. Systems have been implemented to mitigate health and safety risks to residents, staff and visitors relating to this project such as barrier fencing and temporary walls. There are weekly site safe health and safety meetings between Oceania and the building contractors, work safe signage, discussions and safety updates at staff and resident meetings, architect approval and ‘hazard hunts’ by staff.  | The hazard and mitigations strategies relating to the recladding are not referenced in the facility hazard register. The register was updated to include these hazards and mitigation strategies prior to the conclusion of the audit. | Ensure that all identified hazards are entered onto the hazard register. 30 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| No data to display |

End of the report.