

Oceania Care Company Limited - Holmwood Rest Home

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](#).

The specifics of this audit included:

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| Legal entity: | Oceania Care Company Limited |
| Premises audited: | Holmwood Rest Home |
| Services audited: | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 26 April 2018 End date: 27 April 2018 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 49 |

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 |
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|  | 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 |
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| | 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

Holmwood Rest Home and Hospital (Oceania Healthcare Limited) can provide care for up to 52 residents requiring care at either rest home or hospital level. Occupancy on the day of the audit was 49. This surveillance audit has been undertaken to establish compliance with the relevant Health and Disability Services Standards and the district health board contract.

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

The previous requirement for improvement relating to adverse events has been closed. There is an improvement required relating to service delivery timeframes.

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. |
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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 is accessible. This information is provided to the residents and their families on admission to the facility. Residents confirmed their rights are being met, staff are informed and are respectful of the residents needs and communication is appropriate.

The business and care manager is responsible for the management of complaints. A complaints register is maintained and up to date.

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. | | Standards applicable to this service fully attained. |
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Oceania Healthcare Limited is the governing body and is responsible for the services provided at this facility. A business plan and quality and risk management systems document the scope, direction, goals, values and mission statement of the facility.

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.

The quality and risk management system supports the provision of clinical care at the service. Systems are in place for monitoring adverse events and the quality of services provided. Quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status and clinical indicator reports. Corrective action plans are documented with evidence of resolution of identified issues.

The business and care manager, is responsible for the overall management of the facility and is supported by the regional and executive management team. The clinical manager is responsible for the oversight of the clinical service provision in the facility. Staffing levels are adequate across the service. Human resource policies are current and implemented. Registered nurses are on

duty 24 hours a day and are supported by adequate levels of care and allied health staff. On-call arrangements for support from senior staff are in place. There has been one sentinel event since the previous audit.

Continuum of service delivery

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| <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 low risk.</p> |
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Residents receive services from suitably qualified and experienced staff. The residents' files reviewed demonstrated the initial care plans were conducted within the required timeframes.

Care plan evaluations are documented, resident-focused and indicate progress towards meeting the desired outcomes. Where an acute problem occurs a short term care plan is completed. Residents and family members have an opportunity to contribute to assessments, care planning and evaluations of care.

Activities are planned and the activities programme includes a wide range of activities and involvement with the wider community.

The medicines management system is documented and implemented to provide safe processes for prescribing, administration and medication reconciliation, dispensing, storage and disposal of medicines. The medicines policy includes a section on the self-administration of medicines. The residents who self-administer their medicines do so according to policy. Staff responsible for medicines management complete annual medication competencies.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines. There is a central kitchen and on-site staff that provide the food service. The kitchen staff have completed food safety training.

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. |
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There is a current building warrant of fitness. There have been no building modifications since the last audit.

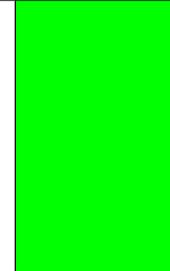
Restraint minimisation and safe practice

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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. |
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The service has documented policies and procedures for restraint minimisation and safe practice. The restraint coordinator confirmed that enabler use is voluntary. There were three residents using restraints and two residents requesting the use of enablers. The residents' files reviewed demonstrated that the policies and procedures relating to restraint minimisation and safe practice are followed.

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.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results are reported through all levels of the organisation. The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided.

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 | 15 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 38 | 0 | 1 | 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 |
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| <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 organisation's complaints policy and procedures are in line with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code). Complaint forms are available at the entrance of the facility. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; the outcome and agreed action. Evidence relating to each complaint lodged, is held in the complaints folder. Complaints reviewed in 2018 indicated that the complaints are investigated promptly with the issues resolved in a timely manner. There are currently no external complaints.</p> <p>The business and care manager (BCM) is responsible for managing complaints.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Information is provided to residents and their families as part of the information pack that is given to the resident on admission. The resident admission agreement, signed by residents or their representative on entry to the service, details the services that are included in service provision and those services that are paid for by the resident.</p> <p>Residents meetings inform residents and family members of facility activities and provide an opportunity for residents and family members to discuss issues/concerns with management. Minutes of residents meetings were sighted. Review of residents' clinical files evidenced timely and open communication with</p> |

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| | | <p>residents and family members. Communication with family members is recorded in the progress notes and on the family communication sheets. Two newsletters have been sent out to residents and families in 2018. Residents and families confirmed the newsletters were informative.</p> <p>Staff, management and families, confirmed family members are kept informed about any change in a resident's condition and if any adverse event occurs. This was evidenced in the clinical files reviewed.</p> <p>Interpreter services can be accessed from the district health board if required. There were no residents at the facility requiring interpreter services on the audit days.</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> | FA | <p>Holmwood Rest Home and Hospital is part of Oceania Healthcare Limited with the executive management team including: the chief executive; general manager; regional manager; operations manager and clinical and quality manager providing support to the service. Communication between the service and the executive management takes place regularly on a monthly basis.</p> <p>The monthly business report provides the executive management team with progress against identified indicators. The Oceania Healthcare Limited mission, values and goals are communicated to residents, staff and family through posters on the wall, information in booklets and in annual staff training and education.</p> <p>The facility can provide care for up to 51 residents with 49 beds occupied at the time of audit. Occupancy included 19 residents requiring rest home level care and 30 requiring hospital level of care. There were two residents identified as being under the young people with disability contract.</p> <p>The BCM is responsible for the overall management of the service. The BCM is a registered nurse (RN) and has been in the role for three years, with previous experience in aged residential care with Oceania Healthcare Limited. The clinical manager (CM) is responsible for the oversight of the clinical service provision in the facility and has been in the role for six years.</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>Holmwood Rest Home and Hospital implements the Oceania Healthcare Limited quality and risk management framework to guide practice. The business plan is documented and reporting occurs through monthly reports and meetings with the regional manager. Reporting includes; financial monitoring; review of staff costs; progress against the healthy workplace action plan; and review of complaints and incidents.</p> <p>The service uses organisational policies and procedures to support and guide service delivery. All policies are reviewed and current. Policies are linked to the Health and Disability Sector Standards, current/applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff. New and revised policies are discussed at the monthly staff meetings and are signed by staff to</p> |

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| | | <p>confirm they have read and understand the policies.</p> <p>There are monthly meetings scheduled to include, management; health and safety; staff; quality; registered nurse; resident and family meetings. All staff interviewed reported that they are kept informed of quality improvements. Service delivery is monitored through complaints; review of incidents and accidents; surveillance of infections and implementation of an internal audit programme. The internal audits reviewed show evidence of processes in place to implement changes that are required as a result of the internal audit. Quality improvement data is analysed through meetings and benchmarking.</p> <p>Health and safety policies and procedures are in place for the service, which include a documented hazard management programme and a hazard register for each part of the service. Any hazards identified are signed off as addressed and risks are minimised or isolated.</p> <p>There is a six monthly satisfaction survey for residents and family. The 2018 surveys indicate that residents and family are satisfied with services provided. This was confirmed through interviews with family and residents on the days of audit.</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>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. Where an authority has been notified, this is documented and retained in the relevant file.</p> <p>Accident/incident reports selected for review had corresponding documentation in progress notes to inform staff that the incident occurred. There is evidence of open disclosure for recorded events. Incident/accident reports are signed off by the BCM. Information is shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania Healthcare Limited facilities.</p> <p>Staff receive education on the incident and accident reporting process at orientation and as part of the ongoing training programme. Staff understand the adverse event reporting process and are able to describe the importance of recording near misses. The previous requirement for improvement relating to adverse events reporting has been closed.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p> | <p>FA</p> | <p>Human resource policy and processes are in place and implemented. All RNs, including the BCM and CM, hold current annual practising certificates. The current visiting practitioners' practising certificates, including general practitioners, pharmacists, and physiotherapist, have been reviewed and were current. Staff files include employment documentation. An annual appraisal process is in place with all applicable staff having a current performance appraisal. Staff files include employment documentation such as: job</p> |

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| <p>accordance with good employment practice and meet the requirements of legislation.</p> | | <p>descriptions, contracts and appointment documentation on file. Police and drug checks are completed.</p> <p>An orientation programme is available for staff. New staff are required to demonstrate competency on a number of tasks, including personal cares. The staff orientation covers the essential components of the service provided. Staff files show completion of orientation. Staff interviews described the buddy system in place for new staff and confirmed the competency sign off process is completed.</p> <p>Mandatory training is identified on an Oceania-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 held. The service has a varied approach to ensuring that staff receive annual training that includes attendance at in-service, external training sessions and annual individualised training around core topics. The training register and training attendance sheets show staff completion of annual competencies, including medication. Relevant and ongoing training is provided to ensure non acute medical and YPD residents are provided with the specific care that is required to meet their needs.</p> <p>There are six of the seven RNs plus the BCM who have completed interRAI training.</p> <p>Education and training hours exceed eight hours a year for all staff reviewed. The healthcare assistants (HCAs) stated they value the training.</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>Staffing levels are reviewed for current and anticipated workloads; staff numbers and appropriate staff skill mix; and the number of residents.</p> <p>Rosters reviewed reflected staffing levels that meet resident acuity; bed occupancy; and the staffing requirements as per the contract in relation to the level of care required. There is a process in place to source additional staff in periods of unplanned absences and increased acuity levels. Residents and families interviewed confirm that there is sufficient staff to meet the residents' needs.</p> <p>The BCM and CM share on call on a week by week basis.</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>Medication areas evidence an appropriate, secure medicine dispensing system which is free from heat; moisture and light; with medicines stored in original dispensed packs. Weekly checks and six monthly physical stocktakes of medications are conducted. The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range. There is a process for checking and managing expired medicines.</p> <p>All staff authorised to administer medicines have current competencies. The medication round was observed and evidenced the staff member was knowledgeable about the medicine administered. Administration records are maintained, as are specimen signatures. Staff education in medicine</p> |

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| | | <p>management is conducted.</p> <p>The residents who wish to self- administer medicines are assessed as competent to self -administer medicines, including residents under 65 years of age and do so according to policy.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people. The menu has been reviewed by a dietitian. The kitchen manager and kitchen staff have safe food handling qualification and completed relevant food handling training.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet residents' nutritional needs and disabilities, was sighted.</p> <p>Food procurement; production; preparation; storage; transportation; delivery and disposal complies with current legislation and guidelines.</p> <p>The residents' satisfaction with meals was verified by resident and family interviews and resident meeting minutes.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>The PCCPs evidence detailed interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records are current. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the</p> | FA | <p>A social assessment and history is undertaken on admission to ascertain: residents' needs; interests; abilities; and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated</p> |

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| <p>service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | | <p>regularly and as part of the formal six monthly PCCPs review (refer to 1.3.3.3).</p> <p>The planned monthly activities programme sighted matches the skills; likes; dislikes; and interests identified in residents' assessment data reviewed. The programme also includes activities specifically for residents under 65 years of age. The activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual and group activities, and regular events are offered. The activities programme is discussed at the residents' meetings and indicated residents' input is sought and responded to.</p> <p>Residents interviewed confirmed they find the programme meets their needs.</p> |
| <p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>Resident care is evaluated on each shift and reported in the residents' progress notes. If there are any changes noted, it is reported to the RN.</p> <p>Formal PCCPs evaluations, following reassessment, including interRAI assessment, to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change (refer to 1.3.3.3). Care plan evaluations are conducted by the RN, with input from residents, family, HCAs, activities staff and GP. There was evidence of allied health care staff input when this was required.</p> <p>A short-term care plan is initiated for short-term concerns. Short-term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews, verified residents and family are included and informed of all changes.</p> |
| <p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>The building has a current building warrant of fitness which is displayed in the entrance.</p> |
| <p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p> | <p>FA</p> | <p>The infection prevention and control surveillance policy identifies the requirements around the surveillance of infections. The type of surveillance undertaken is appropriate to the size and complexity of this service. Infection logs are maintained for infection events. Monthly surveillance analysis is completed and reported at monthly staff meetings and entered in the clinical indicators on the Oceania intranet. This information is</p> |

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| <p>and methods that have been specified in the infection control programme.</p> | | <p>reviewed by the Oceania clinical quality team and reported to the Oceania board on a monthly basis.</p> <p>The residents' files evidenced the residents' who were diagnosed with an infection had short-term care plans in place.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the CM, RNs, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>There have been no outbreaks in the facility since the last 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 definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded and implemented.</p> <p>There were two residents at the facility requesting the use of enablers and three residents using restraint on the days of the audit. The restraint and enabler use are documented in residents' care plans.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.</p> <p>There was evidence that restraint minimisation and safe practice education and training is provided.</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.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | PA Low | <p>Processes are in place to support service provision, however, not all assessments, planning and evaluations are completed in a timely manner.</p> <p>Review of five residents' files evidenced in two of five files PCCPs were not completed within three weeks of admission; and the evaluation of the PCCPs did not occur within the six month timeframe. The interRAI assessments were not completed within the three weeks of admission in two of five files reviewed.</p> | <p>i) The initial interRAI assessments and the PCCPs are not consistently completed within the required three weeks of residents' admission.</p> <p>ii) The PCCPs are not consistently evaluated within the required six month timeframe.</p> | <p>Provide evidence the required timeframes of service delivery (assessment, care planning and evaluation) to be adhered to.</p> <p>180 days</p> |

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.

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End of the report.