# Springlands Senior Living Limited - Springlands Lifestyle 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](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:** Springlands Senior Living Limited

**Premises audited:** Springlands Lifestyle Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 10 April 2018 End date: 11 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:** 52

# 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

Springlands Lifestyle Village provides rest home and hospital (geriatric and medical) level care for up to 56 residents in the care centre and rest home level care across 20 serviced apartments. There were 52 residents on the day of audit.

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

The village manager has been in the position for seven years. She has a New Zealand Diploma in Management and is supported by a clinical nurse manager who has been in the role for five years.

The service continues to have an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

One of two shortfalls identified as part of the previous audit have been addressed. These were around reporting pressure injuries. A further improvement continues to be required around aspects of care intervention.

This audit has identified an improvement required around reporting internal audit outcomes to staff.

## 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. |

The service has a culture of open disclosure. Families are regularly updated of residents’ condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

## 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. |

There is a business plan with goals for the service that has been regularly reviewed. There is a quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

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

## 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.

## 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 service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints and two with enablers at the time of the audit.

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

## Summary of attainment

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

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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 | 14 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 1 | 1 | 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 complaints procedure is provided to residents and relatives at entry to the service. An up-to-date electronic complaints log is maintained by the village manager. There have been seven complaints made in 2018 (YTD). Meals have been a re-occurring theme, and the service is in the process of reviewing the meals and meal service as a result of complaints received. Hospital relatives interviewed, agreed that the service continues to consult them regarding meals and they are involved in the process to improve services.  All complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered.  Residents (two rest home and three hospital) and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. On admission, all residents are provided with an information pack, which gives a comprehensive range of information regarding the scope of service. Relatives (four hospital and one rest home) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management and two monthly resident meetings. Six accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Springlands Retirement Village provides rest home and hospital (medical and geriatric) level care for up to 56 residents and up to 20 licence to occupy serviced apartments approved as being able to provide rest home care. All rooms in the hospital and rest home wings are dual-purpose.  On the day of audit, there were 52 residents. There are three rest home level residents in the serviced apartments (upstairs). There are 49 residents in the rest home/ hospital (down stairs). There are 18 residents at hospital level, including one palliative care resident, and 31 residents at rest home level.  The service is overseen by a board of directors. The village manager documents quarterly reports to the board and shareholders and monthly reports to the managing director. The village manager has been in the position for eight years. She has a New Zealand Diploma in Management.  A clinical nurse manager is employed to oversee the running of the rest home and hospital. The clinical nurse manager has been in the role for five years and has previous management experience; she has completed a master’s degree in nursing and is a Careerforce assessor.  There is a business plan and risk management plan that documents the mission, philosophy and goals of the business for the current year.  The village manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Springlands rest home and hospital has a documented quality and risk programme in place.  There are policies and procedures 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. Staff interviewed (five healthcare assistants, four registered nurses, one chef, one diversional therapist and the health and safety officer) confirmed they are made aware of any new/reviewed policies. There are sufficient clinical policies/procedures to support hospital level care.  Monthly complaints and quality meetings, monthly management meetings and bi-monthly staff meetings minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs.  Additional facility meetings held include: health and safety, kitchen meetings, resident and relative meetings, and registered nurse meetings. The staff interviewed were aware of quality data results, trends and corrective actions.  There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Corrective actions are developed, implemented and signed off, however these are not documented as discussed with staff.  There is an implemented health and safety and risk management system in place including policies to guide practice. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.  Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this. |
| 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 service collects incident and accident data on incident forms and enters them into an electronic register. Incidents and accidents are collated monthly and reported to staff via meetings.  Incidents in February included 26 resident falls. Ten falls-related incidents were randomly selected for review. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process. The clinical nurse manager collects incident forms, investigates and reviews and implements corrective actions as required.  Six pressure injuries (one current), all had a corresponding incident form. This is an improvement on the previous audit.  The village manager interviewed, could describe situations that would require reporting to relevant authorities. The service has reported four fractures to the Ministry of Health. |
| 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 | There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Six staff files were reviewed (two RNs, two healthcare assistants, one diversional therapist and one cook). All files contained relevant employment documentation including current performance appraisals and completed orientations. Current practising certificates were sighted for the registered nurses. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care.  Staff interviewed believed new staff are adequately orientated to the service on employment.  There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. Six of the seven RNs have completed interRAI training. The RNs and clinical manager have completed syringe driver training and have access to external training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a policy to determine staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The village manager (non-clinical) and the clinical nurse manager/RN are on duty during the day Monday to Friday and available on-call.  Rosters include;  Hospital, 18 residents at the time of audit.  There is a RN on duty 24 hours.  AM; Healthcare assistants - two long shifts and one short shift (plus one additional short shift dependant on acuity). PM; two long shifts and one short shift. Night; one HCA.  Rest home, 31 residents’ downstairs and three in the serviced apartments upstairs.  There is an RN on duty during the day, seven days a week.  AM; Healthcare assistants - one long shift and one short shift, plus a kitchenhand to assist with meal services and morning and afternoon tea. PM; one long shift and two short shifts, plus a kitchenhand to assist with meal services. Night; One HCA.  Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RN, and clinical nurse manager and facility manager who respond quickly to after-hour calls. |
| 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 medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have an individual electronic medication chart with photo identification and allergy status documented. The service uses a packaged medication system for tablets, and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident’s medicine order when new medicines are supplied from the pharmacy. Short-life medications (i.e., eye drops and ointments) are dated once opened. There was an in-depth medication review documented during August 2017 and an action plan was developed and has been followed up. Weekly medication housekeeping checks are also implemented by the clinical nurse manager  Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three-monthly. All prescribed medication was signed by the GP, as needed medications had indications for use and the medication chart was signed each time a medicine was administered by staff.  A registered nurse was observed administering medications and followed correct procedures. Two residents in the rest home self-administer medicines and have current competency assessments around this. They have access to secure storage in their rooms. Staff check each shift that these residents have safely self-administered their medications and record this on the medication administration sheet. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared and cooked on-site at Springlands Lifestyle Village. There is a four-weekly seasonal menu which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. Pureed and gluten free diets and diabetic desserts are provided. Cultural and religious food preferences are met. The service is currently in the process of reviewing and improving meals services in association with family members. This initiative was implemented as a result of complaints about meals.  Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family interviewed agreed that the service has worked hard to improve services as a result of feedback.  Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures and food temperatures prior to the food being served to the residents at Springlands Lifestyle Village, are recorded. All food services staff have completed or are enrolled in training in food safety and hygiene and chemical safety. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Care plans sampled were goal orientated, however some care plan intervention updates were documented in evaluation sections. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary.  There were nine wounds in the hospital and six wounds in the rest home being managed at the time of the audit. One rest home resident had a grade one pressure injury. Assessments, management plans and documented reviews were in place for all wounds but not always reviewed according to timeframes.  Specialist nursing advice is available from the DHB as needed. A physiotherapist is available as needed.  Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed.  Residents and family members interviewed, confirmed their satisfaction with care delivery.  The previous audit shortfall around fully completed wound documentation and registered follow-up of identified issues has been rectified. However, a new shortfall around timely wound evaluations and care plan interventions has been identified. |
| Standard 1.3.7: Planned Activities  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. | FA | The service employees a qualified diversional therapist (DT) full time Monday to Friday, who coordinates the activities programme for the hospital and rest home. A part-time diversional therapist works two days a week in the hospital wing. The weekend programme is delivered by care staff and volunteers.  Group activities are provided in communal rooms, in seating areas and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance.  Individual activities are provided in resident’s rooms or wherever applicable.  On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly, and a weekly programme is published each week for the residents. The group programme includes residents being involved within the community with social clubs, churches and schools.  The DT interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.  A record is kept of individual resident’s activities. The resident/family/EPOA as appropriate is involved in the development of the activity plan. Participation in all activities is voluntary.  Residents interviewed were complimentary of the activities provided and the two DTs. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Care plans also included a written evaluation of care (link 1.3.6.1). Care plan reviews are signed as completed by the RN. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is prominently displayed. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility, including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. The outbreak of confirmed Norovirus during December was reported to the appropriate authorities including daily briefings to public health. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints and two with enablers at the time of the audit. Both residents with enablers had a documented assessment and consent, three monthly review by the restraint team and monthly reviews in the care plan. |

# 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 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The service has a robust and implemented internal audit programme. Audits reviewed, all documented an action plan, where issues had been identified and action plans were signed off when completed. Internal audits were not documented as discussed with staff at meetings. | A review of facility meetings evidenced that internal audits were not documented as discussed with staff | Ensure that internal audits are documented as discussed with staff.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Care plans were in place for all residents. Interventions were overall documented for residents assessed needs, however, not all interventions were documented, and some updated care plan interventions were included within the narrative of evaluations rather than in the care plan. Wound care plans were in place and fully documented for all identified wounds. However, not all wounds reviewed had been evaluated within set timeframes. | (i)Of the nine wounds reviewed for the hospital and six for the rest home; two hospital and one rest home had not been evaluated/redressed within set timeframes.  (ii) One hospital level resident’s care plan included updated interventions documented in the evaluation section rather than in the intervention section. (iii) one hospital level resident’s care plan did not include interventions for dehydration (as identified by the interRAI) and the signs and symptom and interventions were also not documented for this resident with insulin. | (i)Ensure that wounds are evaluated/redressed according to set timeframes. (ii) Ensure that care plans document all care needs.  60 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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End of the report.