

# Lara Lodge 2017 Limited - Lara Lodge

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## 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 HealthShare 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:

<b>Legal entity:</b>	Lara Lodge 2017 Limited
<b>Premises audited:</b>	Lara Lodge
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 24 July 2019    End date: 24 July 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	19

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Lara Lodge can provide rest home level care for up to twenty-seven residents. There have been no changes to the facility since the last audit. There has been a change to the management structure with the role of the previous clinical nurse manager being replaced with a clinical lead.

The unannounced surveillance audit was conducted against a sub set of the Health and Disability Service Standards and the organisations contract with the District Health Board. The audit process included the review of policies and procedures; a sample of resident and staff files; observations, and interviews with family, management, staff and the owners/directors. A general practitioner was not available for interview during the audit.

Previous areas requiring improvement have been addressed. There were five areas requiring improvement identified during this audit. These were in relation to the documented complaints procedure, staff training requirements, the medication management system and the food service.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Management and staff communicate in an open manner and residents and relatives are kept up-to-date when changes occur. Systems are in place to ensure residents/family are provided with appropriate information to assist them to make informed choices and give informed consent. Resident meetings provide residents and family members to discuss compliments and concerns. There have been no formal complaints during this certification period.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The owners/directors continue to monitor organisational performance with the support of the clinical lead and experienced health care assistants. The required policies and procedures are documented and available. There is a quality plan with key quality objectives. A range of quality data is collected. An internal audit schedule is implemented. Adverse events are managed in line with best practice and reported as required.

The human resource management system has been maintained and is consistent with accepted practice. There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery for all residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Service provision is provided in a manner that promotes continuity in service delivery and a team approach to care delivery. All processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that meet the needs of the resident. InterRAI assessments and individualised care plans are completed. When there are changes to the resident's needs, a short-term plan is developed and integrated into a long-term plan, as needed.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. In interview, residents and family/whanau expressed satisfaction with the activities in programme.

The medicine administration system was observed at the time of audit. Staff competency assessments are maintained. A resident assessment to ensure safety to self-administer medicines, is in place.

Food services meet the preferences for residents and special diets are catered for.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There have been no changes to the facility since the last audit.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There were no residents using a restraint or enabler at the time of the audit.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection surveillance programme is appropriate for the size and complexity of the organisation.

## 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)
<b>Standards</b>	0	13	0	1	3	0	0
<b>Criteria</b>	0	37	0	2	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The complaints procedure is explained to residents and family members as part of the admission process. In interview, family members and residents confirmed that management has an open-door policy which makes it easy to discuss concerns at any time. There are additional processes for obtaining resident and family feedback. Resident satisfaction is monitored and resident meetings are conducted.</p> <p>There is a complaint register, however there have been no formal complaints during this certification period. It was also reported that there have been no complaints to external agencies.</p> <p>An improvement is required regarding the documented complaints procedure.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Information is provided in a manner that the resident/family members can understand. It is reported that family and residents can discuss issues at any time with staff or management. The adverse event reporting system includes an area to document if the family members have been contacted. Open disclosure is practised in the event an error has occurred. This was evident in records of adverse events sampled.</p> <p>Residents and family members interviewed confirmed that they are kept well informed, and that management and staff communicate in an open manner. Family members confirmed that they are advised if there is a change in their family member's health status and are invited to attend resident meetings.</p>



communication.		There is a policy regarding the use of interpreters. There were no residents requiring the services of an interpreter at the time of the audit.
<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>There have been no changes in governance or ownership since the last audit. There are two owners/directors. One director identifies as the facility manager and the other identifies as the communications manager. The communications manager is also responsible for human resources and some quality activities. The owners/directors live on site and state they are supported by an external accountant, who also consults on health and safety matter, the clinical lead and the district health board (DHB) portfolio manager. Lara Lodge also belongs to the national group of smaller aged care providers and receives ongoing support and newsletters from this group.</p> <p>Organisational performance is monitored by the owners/directors who are both on site Monday to Friday, business hours. Both owners/directors were interviewed and confirmed their day to day involvement in the business, plus their availability after hours. The philosophy, code of ethics and values of the organisation are documented and are being reviewed in an ongoing manner.</p> <p>The clinical lead replaced the clinical nurse manager in 2018. The clinical lead was previously employed as a registered nurse at Lara Lodge. The clinical lead is supported by the other registered nurse and maintains the required professional development hours including accessing relevant training topics provided by the DHB.</p> <p>On the day of audit, there were 19 residents requiring rest home level of care and one resident who was under the aged of 65 years. It was reported that both the Ministry of Health and the DHB were aware of the circumstances surrounding this admission. The service can also provide care for residents identified under the long-term support - chronic health conditions contract or palliative care, however there were no residents requiring care under these contracts on the day of audit.</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>Policies and procedures are reviewed every two years or more frequently as required. The 2019 review was in process at the time of the audit. Policies reflect current good practice, legislation and compliance requirements. Policies and procedures are accessible to staff. There is a system for updating, reviewing, approving, controlling and removing obsolete documents from circulation (refer standard 1.13 regarding the documented complaints procedure.)</p> <p>There is a quality plan with defined objectives. A range of quality related data gathered. This includes resident feedback, infection control surveillance, health and safety, adverse events and internal audits. An improvement is required regarding the collation and reporting of this data.</p> <p>The quality system requires quality related data to be collated and reported at staff meetings. There is a set template for staff meetings which includes a section on quality related data. Collated adverse events, infection</p>

		<p>control surveillance, health and safety and the results of internal audits are routinely being discussed at this forum.</p> <p>The internal audit schedule is implemented. Checklists for internal audits are provided by an external consultant. There is evidence that corrective actions are documented and implemented where a variance is identified. Information regarding resident satisfaction is included in the internal audit programme. Resident satisfaction audits sampled confirmed general satisfaction with the services provided.</p> <p>A risk management plan is documented. It was reported that risks are discussed regularly between the clinical lead and owners/directors. Health and safety requirements are being maintained, including hazard identification. Health and safety requirements are also maintained through checks of the premises each month. Clinical risk is documented in individual resident records.</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>	FA	<p>The clinical lead and communications manager are aware of situations in which the service would need to report and notify statutory authorities. For example, the Ministry of Health was advised of a pressure injury in April of this year.</p> <p>A sample of the adverse event records confirmed that incidents and accidents are being reported and followed up in an appropriate and timely manner. Records included evidence of immediate responses, investigations and remedial actions being implemented as required. This includes reporting to family members and informing the general practitioner if required. Family members interviewed confirmed that incidents are reported in a timely manner. There was also evidence of open disclosure in the event that an error had occurred.</p> <p>All adverse events are entered onto a monthly register. This is analysed annually and can be compared with previous annual results. The majority of adverse events has been falls. Adverse events are collated and discussed at staff meetings.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>Staff records sampled included an employment agreement and a position description. Staff have criminal vetting prior to appointment, reference checking and professional qualifications are validated. All staff receive an orientation and participate in ongoing refresher education. The orientation programme includes the essential components of service delivery and all new staff are buddied by a senior member of the team until they are assessed as competent with their required duties.</p> <p>A training plan is documented and implemented annually with regular training sessions offered. Staff are provided with both internal and external training. The clinical lead and registered nurses have completed the interRAI training. Mandatory competencies include medication and hoist training. The required competencies were sighted. Performance appraisals are completed for all staff and this ensures that any individual training</p>

		<p>needs are identified.</p> <p>The registered nurses have current practicing certificates and maintain their professional portfolio's. An improvement is required regarding first aid certificates.</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>	FA	<p>The process for determining staffing levels and skill mix is defined in policy and takes into account the layout of the facility. Staff rosters are developed by the communications manager with oversight from the clinical lead. Rosters sampled confirmed that there are sufficient numbers of staff to meet the needs of the residents, with shift gaps covered in the event of a temporary absence.</p> <p>There are 18 staff members including the clinical lead who is on site 40 hours per week. There is another registered nurse who completes one shift per week and is available to support the clinical lead if required. There are designated health care assistants, domestic staff, kitchen staff and an activities coordinator. The clinical lead and the owner/directors are on call after hours.</p> <p>There are two health care assistants on duty during the day shifts and one staff member on duty during the night. The clinical lead and activities coordinator are additional to the roster. Residents and families interviewed confirmed staffing is adequate to meet the residents' needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Individual resident records are maintained and secure. Records sampled were current with all entries legible, dated and signed. Designation of the writer was documented. The previous area of improvement regarding the separation of resident records has been addressed. Resident information is now stored in two files. One file includes medical and allied health information and the other includes the assessment, care plans, reviews and progress notes. Information is cross referenced between the files where required. Staff report that this system is working well and ensures continuity and integration of records.</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</p>	PA Moderate	<p>The medicine management policy is current and identifies all aspects of medicine management in line with current legislation, regulation and protocols. A paper-based medication system is in place. A health care assistant was observed administering medication correctly. All staff who administer medicines were assessed as competent and evidence of competencies was sighted. There were two residents self-administering medications at the time of the audit. Appropriate processes were in place to ensure this is managed in a safe manner. An improvement is required regarding the transcribing of medication.</p>

and safe practice guidelines.		
<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>	PA Moderate	<p>Diets are modified as required and the chef confirmed awareness of dietary needs of the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required. Kitchen staff completed training in food safety/hygiene. The kitchen has a current food safety plan.</p> <p>An improvement is required regarding the menu review and food plan.</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 documented interventions in short term care plans and long-term care plans are enough to address the residents' assessed needs and desired goals/outcomes. Interventions are updated when required and interRAI triggered outcomes are addressed. Specialist advice is sought from other service providers when required. Referral documents to other services and organisations involved in residents' support were sighted in the files sampled. Interviewed families and residents reported satisfaction with the services provided. Interviewed staff reported that there are adequate resources to meet safe resident care. Adequate medical/clinical resources were sighted and were appropriate to the size and scope of the facility.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Activities are planned by the activity coordinator in consultation with the clinical lead. A monthly planner is distributed to all residents and displayed on the white board. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Residents and their family/whanau are consulted in the activity assessment and planning process. There is a wide range of activities offered including bingo, quiz, music sessions, brain games, scrabble, happy hour and housie. External entertainers are invited including church and music groups. Van outings are conducted twice a week to areas of interest. Activities range from group, one on one and cater those under 65 years of age. Attendance checklists and documentation is completed. The residents' activity needs are evaluated by the activity coordinator in consultation with the clinical lead every six months.</p> <p>Monthly residents' meetings are conducted, outcomes are implemented and communicated to family/whanau and residents. Interviewed residents and family members reported satisfaction with the activity programme. Residents were observed participating in a variety of activities on the days of the audit.</p>
Standard 1.3.8:	FA	Resident care is evaluated on each shift and reported in the progress notes. Any change is noted and reported

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>to the clinical lead. Residents' care plans, interRAI assessments and activities plans are evaluated at least every six months and updated when there are any changes. Family/whanau and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the condition resolves.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There have been no changes to the facility since the last audit. The current building warrant of fitness was sighted. The original approved fire evacuation plan was sighted, dated 1994, with a review completed in 2017. Fire drills are completed as required.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The clinical lead is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections are documented. All diagnosed infections are entered onto a monthly register and collated annually. The register includes the type of antibiotic and the resolution date. The annual review confirms a comparatively low infection rate, with minimal infections over the winter months. Collated infection control surveillance data is discussed at staff meetings.</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 restraint minimisation policy provides consistent definitions for restraints and enablers. All staff receive education regarding restraint minimisation and challenging behaviours. Confirmation regarding the previous area of improvement could not be confirmed during this audit, as there were no residents using a restraint or enabler at the time of the audit, however templates developed for restraint use were detailed and included the required information.</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)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	A complaints policy and procedure is documented and is available to residents and family members. The documented complaints procedure did not reference Right 10 of the Code or include the Health and Disability Commissioner timeframes for the management of complaints. This was corrected on the day of the audit and will now need to be implemented.	The amended documented complaint procedure has not yet been implemented.	<p>Implemented and newly amended documented complaints procedure.</p> <p>180 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Moderate	There is evidence that staff have the required skills and competencies, with the exception of first aid certificates. All staff at Lara Lodge are required to have a current first aid certificate, including the registered nurses. The majority of staff's first aid certificates have expired, however there is still access to a staff member with a first aid certificate on each shift. It was reported that the owners/directors are currently seeking a new provider for first aid training. There was evidence that a	Not all staff have a current first aid certificate, as required by the	All staff are required to have a current first aid certificate.

		new provider of first aid training has been found and a date for training will now be confirmed.	organisation.	60 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Residents receive medicines in a safe and timely manner. The service uses a pre-packed medication system and medicines are supplied by the contracted pharmacy. All medication packs are checked by the clinical lead on delivery against the medication charts every two weeks. Unused medicines are returned to the pharmacy promptly. The service does not stock any vaccines or unprescribed medications. The GP conducts three monthly reviews of medication charts.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and all controlled drugs are stored appropriately. All medication is safely stored in locked cupboards and drug trolley.</p> <p>There was evidence of transcribing of medicines on the 'as required' (PRN) medication records. Transcribing included the name, dose and frequency of the medication to be administered.</p>	<p>Medicines were being transcribed on the administration records of 'as required' (PRN) medication.</p>	<p>Cease transcribing PRN medications.</p> <p>30 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Moderate</p>	<p>The food service is provided on site by a qualified chef and the kitchen team. The daily menu is documented in a diary and residents' input is considered and acted upon. The previously approved menu is not being consistently followed as residents are provided with the meals of their choice and offered alternatives. All residents interviewed reported satisfaction with the meals provided. A nutritional profile is developed on admission and reviewed every six months or when there is any significant change.</p> <p>The provider has applied for a food plan; however, the plan was not sighted.</p>	<p>The menu which was approved by a dietician is not the menu which is being consistently provided. The food plan was not sighted.</p>	<p>Provide evidence that the menu which is being provided meets the nutritional needs of the older person and a copy of the food plan.</p> <p>90 days</p>

<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>The kitchen and pantry were sighted and observed to be clean, tidy and well stocked. Labels and dates were on all decanted food containers. Regular cleaning is conducted. There was insufficient evidence that regular temperature monitoring of the fridge and freezer was being completed as required.</p> <p>Some expired dry goods were sighted in the pantry. It was reported that these belonged to the owners, who live on site and use the rest home kitchen for their meal preparation. This was corrected immediately following the audit.</p>	<p>Fridge and freezer temperatures are not being consistently monitored.</p>	<p>Maintain consistent records of fridge and freezer temperatures.</p> <p>60 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.