

Elms Court Rest Home Limited - Elms Court 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Elms Court Resthome Limited

Premises audited: Elms Court Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 10 February 2020 End date: 11 February 2020

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: 17

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
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

Elms Court Rest Home provides care for up to 19 rest home level residents. On the day of the audit there were 17 residents.

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

The owner/director/facility manager has a background in human resources and was the previous assistant manager at Elms Court. She has been in the role for a year. The clinical manager has also been in the role for a year and has previous experience in aged care. They are supported by long-standing staff. Residents, relatives and the general practitioner interviewed were very complimentary of the services and care received.

The service has addressed the previous shortfall around care plan interventions.

This audit identified a shortfall around employment processes.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

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 low risk.
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The facility manager is responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A current quality and risk management programme was documented. Quarterly meetings are held as scheduled. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Employment processes are in place. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. Residents, relatives and staff reported that staffing levels are adequate to meet the needs of the 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.		Standards applicable to this service fully attained.
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The clinical manager/RN is responsible for care plan documentation. InterRAI assessments and care plans are completed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and families advised satisfaction with the activities programme. The service uses an electronic medication management system. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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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Elms Court has a current building warrant of fitness and reactive and preventative maintenance occurs.

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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Elms Court have restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service currently has no residents requiring restraint or enablers.

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.

Elms Court continues to implement their infection surveillance programme. Infection control issues are discussed at both the combined quality meeting and the staff meeting. The infection control programme is linked with the quality programme.

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	40	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
<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>Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register. One complaint was received in 2019, and there have been none to date in 2020. Documentation and correspondence reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Care partners interviewed confirmed that complaints and any required follow-up is discussed at staff meetings as sighted in the minutes. The relative advised that they are aware of the complaints procedure and how to access forms, the residents stated they felt comfortable raising any concerns with staff or management. Residents rights and complaint processes were discussed at a residents meeting following the low number of residents aware of how to make a complaint identified through the 2019 satisfaction survey.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Comprehensive information is provided at entry to residents and family/whānau. Five residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Both the facility manager and clinical manager were available to residents and relatives and they promote an open-door policy. Incident forms reviewed in December 2019, and January and February 2020 evidenced that relatives had been notified on all occasions. The relative interviewed advised that they are notified promptly of incidents and when residents' health status change. The two care partners (caregivers) and the lifestyle coordinator interviewed fluently described instances where relatives would be notified. Interpreter services are available on request.</p>

environment conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Elms Court Rest Home is privately owned and operated and provides care for up to 19 residents requiring rest home level care. On the day of the audit, there were 17 residents in total, including three residents on the long-term support - chronic health contract (LTS-CHC), two on Life links contract funded by the MOH and one under the mental health act. All other residents were under the age-related residential care (ARCC) contract.</p> <p>The service is owned by a husband and wife team. The facility manager (wife) is non-clinical and has been in the role for a year. She is experienced in human resources and was the previous assistant manager for three years. The clinical manager has been in the role for a year and has previous experience in aged care and senior nurse role.</p> <p>Elms Court has a current 2019/2020 business plan. The business plan identifies progress achieving goals. The business plan incorporates the risk management plan and goals for each area of service delivery and organisational management. The manager/owner (husband) is responsible for the operational and financial aspect of the business and manages a sister facility.</p> <p>The facility manager has attended at least eight hours of professional development that relates to managing a rest home including NZ Aged Care Association conference and a management and leadership course. The clinical manager has attended management and leadership training, a wound care study day through CDHB and has access to online training.</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>The quality and risk programme describes Elms Court Rest Homes quality improvement processes. Progress with the quality and risk management programme has been monitored through the three-monthly combined quality/management/clinical/infection control/health and safety meetings. The three-monthly quality/management meetings are held prior to the staff and resident meetings. Quality data, complaints, health and safety, hazard management, internal audits and corrective actions are discussed as sighted in minutes and confirmed during staff interviews. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes for all meetings have included actions to achieve compliance where relevant.</p> <p>An annual resident and relative satisfaction survey was conducted in 2019 and is due to be completed for 2020. Respondents advising that they are overall very satisfied with the care and service they receive. The residents survey identified that the 14 residents who responded were overall happy with the service provided. Corrective actions were put in place around improving and discussing the complaints process at resident meetings as a high number could not recall the complaints process. Air fresheners and replacement of carpets was completed following reports of odours. There was low satisfaction around the food services in the surveys (despite no issues when discussed at the meetings). The menu was reviewed, and second helpings and extra fluids are now offered at</p>

		<p>mealtimes. The relative survey identified relatives always feel well informed, staff are flexible and always interested and go the extra mile especially around special events. There were no corrective actions required for the relative survey.</p> <p>The internal audit schedule for 2019 has been completed and 2020 is being completed as per schedule. Areas of non-compliance identified at audits have been actioned for improvement. The service has implemented a health and safety management system. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored at the quality/management meeting. Hazard identification forms and an up-to-date hazard register (last reviewed 21 August 2019) are in place.</p> <p>Falls prevention strategies are in place that includes the identification of interventions on a case-by-case basis to minimise future falls.</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 manager collects incident and accident data monthly and reports aggregated figures quarterly to the quality meeting. Emergent issues are discussed at the daily staff handovers. Incident forms are completed by the care partners. The resident is reviewed by the clinical manager at the time of event if on site. If the clinical manager is not on site, the care partners inform the clinical manager who assesses the resident immediately if required or when next on duty for non-injury events. The form is forwarded to the facility manager for final sign off. Ten paper-based incident forms reviewed identified appropriate registered nurse follow up. Incident/accident forms include a section to record relatives have been notified. Neurological observations were not completed for two unwitnessed falls as the resident was able to say they had not hit their head. Minutes of the combined quality/staff meetings reflect a discussion of incident statistics and analysis. The care partners interviewed could discuss the incident reporting process. Discussions with both the facility and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no notifications required since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with</p>	PA Low	<p>Five staff files (one clinical manager/RN, three care partners (including the cook/care partner) and one lifestyle coordinator) were reviewed. A current practising certificate was sighted for the clinical manager/RN. The service has an orientation programme in place to provide new staff with relevant information for safe work practice, however, the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role was not documented. Performance appraisals were current. Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service.</p> <p>The clinical manager/RN and care partners complete competencies relevant to their role such as medications, hand</p>

good employment practice and meet the requirements of legislation.		hygiene, restraint and manual handling. There is an education planner in place that covers compulsory education requirements over a two-year period. The clinical manager/RN has completed interRAI training.
<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>Elms Court has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs on different shifts. The manager/owner is on site from 9 am until 3 pm Monday to Friday and is on call 24/7 for any operational issues. There is a clinical manager/RN on site for 20 hours per week or more if required and is also on call 24/7 for any clinical concerns.</p> <p>There are two care partners (Health Care Assistants) on duty on the morning shift, 1x 6 am to 2.30 pm (medicine competent), and 1x 7 am to 10 am (medicine checker) then goes to the kitchen from 10 am to 1.30 pm. The afternoon has two care partners rostered: 1x 2 pm to 10 pm (medicine competent) and 1x 4.15 pm to 6.15 pm kitchen shift (medicine checker). One care partner who is medicine competent works overnight from 10 pm to 6 am. All staff except one care partner, have first aid certificates, this care partner is always working the short shift and always has another care partner on duty.</p> <p>Roster shortages or sickness are covered by casual or off duty staff. The care partners and residents interviewed reported that there is sufficient staff cover.</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>	FA	<p>Elms Court have implemented an electronic medication management system. The supplying pharmacy couriers all medicines in robotic rolls for regular medications and blister packs for 'as required' medications. Medications were checked and signed on arrival from the pharmacy by the clinical manager.</p> <p>The clinical manager and care partners are assessed as medication competent to administer medication, the care partners who also complete kitchen duties are competent as checkers only. Standing orders were available but not in use. The medication fridge temperatures and the room where medications are stored have been monitored weekly and temperatures were within the acceptable range. Ten electronic medication files were reviewed. Medication reviews were completed by the GP three monthly. PRN medications were prescribed correctly with indications for use. Medications are stored securely in the locked nurses' station and the medication trolley is locked and kept in the dining room. There were three residents' self-medicating inhalers, each have a competency in place which has been reviewed by the GP three monthly.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	All meals and baking are prepared and cooked on site by a care partner/cook. Staff who perform kitchen duties have completed food safety training. The food control plan expires 18 February 2021. The four-weekly seasonal menu has been reviewed by a dietitian and is due for review in 2020. Fridge temperatures are taken daily and

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>freezer temperatures weekly. Cleaning schedules are maintained. End cooked food temperatures are taken on all foods daily and recorded. Perishable foods sighted in the fridge were covered and dated. Dried goods in the pantry were dated and goods are rotated when orders are delivered.</p> <p>Resident dislikes are known and accommodated. Meals are plated and served directly from the kitchen area to residents in the dining room. Residents choose the menu on their birthdays. Resident meetings along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and relatives interviewed were very satisfied with the food and confirmed alternative food choices were offered for any dislikes.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the clinical manager/RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence in the progress notes the family/whānau (where appropriate) were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits, referrals and changes in medications. Discussions with the relative confirmed they are notified promptly of any changes to their relative's health. Changes to resident's health are monitored and identified through ongoing daily assessments. Changes to health are reported to the clinical manager/RN who informs the GP or other allied health specialists.</p> <p>Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for two residents (one blister, one lesion and one resolved pressure injury with a protective dressing only). Short-term care plans were in place for both wounds. There is access to a wound nurse specialist if required. Adequate dressing supplies were sighted.</p> <p>Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified.</p> <p>Monitoring forms and short-term care plans provide guidance for the safe delivery of care for short-term needs/supports. An action plan was in place for diabetes management. The form contained information on 'normal ranges' and provided clear instructions for care partners to follow if the blood sugar levels are outside of these perimeters and instructions for follow-up management and monitoring. An information sheet with signs and symptoms of hyperglycaemic and hypoglycaemic episodes is in resident files of insulin diabetics. The previous finding has been addressed.</p> <p>Short-term care plans were sighted for residents who were identified as losing weight unintentionally. Weights have been monitored weekly, supplements have been prescribed by the GP, and smoothies and a high protein diet was in place. Food charts, and fluid balance charts were maintained and the care partners document whether there has been an adequate food and fluid intake in the progress notes, and if the resident is reviewed by the GP.</p> <p>Monitoring forms sighted included electronic weight, vital signs, food and fluid, fluid balance, and blood sugar monitoring. A suite of monitoring charts are available as required.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a lifestyle coordinator with an occupational therapy background. She works 16 hours a week spread over four days a week. Working hours are flexible around resident activities such as outings. A resident social profile is completed on admission. Individual activity plans were seen in the resident files. The lifestyle coordinator is involved in the six-monthly review with the clinical manager/RN.</p> <p>The monthly programme includes activities such as mini golf, quizzes, word builders, exercises, walks, gardening, music, happy hours and news and views. A new initiative is to join with the sister facility and have monthly competitions. Care partners implement the weekend programme that includes movies. The planner is subject to change if the residents choose to participate in other activities, weather permitting.</p> <p>Residents are supported to attend community events including concerts and social afternoons in the community with other rest homes. A company car and taxis are used for outings to the beach, art galleries, and museums. Monthly church services are held, and communion is held on site. One on one time is spent with residents who choose not to participate in group activities.</p> <p>The lifestyle coordinator meets daily with the younger persons to ensure their individual recreational references are being met. They are offered to join in activities and are supported to maintain their interests. The focus for the current younger residents is maintaining a sense of self, a sense of worth and enabling residents to be independent and make their own decisions. Residents (where appropriate) are encouraged to use the bus to get to community activities of their choice. The lifestyle coordinator endeavours to include something for all residents in the planner. Elms Court receives feedback and suggestions for the programme through resident meetings, regular feedback, suggestions and surveys. Residents and relatives interviewed were satisfied with all on site and community activities on offer.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans for long-term residents were evaluated by the clinical manager within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by the clinical manager at least six monthly, using the interRAI tool or earlier for any health changes for files reviewed. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes or the care plan. The short-term care plans of care have been reviewed and evaluated</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	<p>FA</p>	<p>Elms Court holds a current building warrant of fitness expiring on 1 June 2020. Preventative and reactive maintenance occurs, and records are maintained. Hot water temperatures are checked randomly and were within ranges. Tradesmen are available if required. Equipment has been tagged and tested on a two-yearly rotation.</p>

<p>provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>New seated scales have been recently purchased.</p> <p>All areas are accessible for residents using mobility aids. There is a large communal lounge area with a conservatory area for residents and relatives to enjoy. Outdoor areas and gardens are well maintained and accessible to residents. The gardens have seating and shade provided by the trees. There is a designated smoking area for residents.</p> <p>The care partners interviewed stated they have sufficient equipment including mobility aids, wheelchairs and pressure injury equipment (if required), to safely deliver the cares as outlined in the residents' care plans.</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>Elms Court continue to implement their infection surveillance programme. Individual electronic infection forms were completed for all infections. Infections were included on a monthly electronic register. A monthly report and graphs were completed by the infection control coordinator (clinical manager). Infection control (IC) issues were discussed at the combined quality meetings and staff meetings quarterly. Emergent issues are dealt with and discussed at the daily handover and reiterated at the quarterly meetings. The IC programme is linked with the quality programme. In-service education is provided annually and in toolbox talks when required. There have been no outbreaks since the previous 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>Elms Court Rest Home has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents requiring restraint or enablers at the time of the audit. The service is committed to maintaining a restraint-free environment. Staff received training in restraint minimisation and challenging behaviour management in April 2019.</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)
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	The facility manager described performing reference checks for new staff employed to verify qualifications, and suitability for the position, however this was not documented.	Five of five staff files did not have reference checks documented.	Ensure reference checks for all new staff are documented and kept on file. 180 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.