

Orongo Lifecare Limited - Orongo 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 Q-Audit 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:	Orongo Lifecare Limited
Premises audited:	Orongo Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 12 October 2020 End date: 12 October 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:	34

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
	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

Orongo rest home is owned and operated by Orongo life care limited and provides care for up to 46 residents requiring rest home and secure dementia level of care. The manager is a registered nurse who is qualified and experienced for the role. Residents, their families and the general practitioner spoke positively about the services provided.

This unannounced surveillance audit was conducted against the Health and Disability Service Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, management, the registered nurse, staff and the general practitioner.

This audit has not identified any areas for improvement.

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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Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required and contact details are displayed.

A complaints register is maintained with complaints resolved promptly and effectively.

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.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, strategies to meet goals, values and the mission statement of the organisation. The manager reports directly to the owner/director. The risk management system is robust and includes collection and analysis of quality improvement data, identifies any trends and leads to quality improvements occurring. Adverse events are documented with corrective actions as necessary. Actual and potential risks, including health and safety risk are identified. Policies and procedures are reviewed in a timely manner.

Human resource management is based on current good practice. Education is provided at orientation and is ongoing supporting safe practice and service delivery. All staff who work in the dementia unit have undertaken the required training. Staffing levels and skill mix and staff coverage was observed to be adequate for the rest home and the dementia services.

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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A registered nurse is responsible for the provision of care and documentation at every stage of service delivery .There is sufficient information gained through the initial support plans to guide staff along with specific assessments including the interRAI assessment to develop care planning to meet the needs of each individual resident and to provide safe delivery of care. Allied health input and a team approach to care is encouraged.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs 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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The building has a current building warrant of fitness. There have been no changes to the fire evacuation plan. Regular fire drills are conducted.

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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The organisation has policies and procedures that support the minimisation of restraint. Two enablers were in use at the time of audit. No restraints were in use. Use of enablers is voluntary for the safety of residents to enable them to remain as independent as possible. Staff demonstrated a sound knowledge and understanding of the restraint and enabler process.

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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Aged specific infection surveillance is undertaken and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	17	0	0	0	0	0
Criteria	0	42	0	0	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>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaint forms are available in the reception area and from the nurses' station at any time.</p> <p>The complaints register showed four minor complaints had been received since the previous audit. For all internal complaints actions are taken through to an agreed resolution and were documented and completed within the required timeframes required. Action plans showed any required follow up and improvements have been made where possible. The owner/manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. One complaint to the WDHB was managed effectively and closed out. There have been no other complaints received from external sources.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>A resident and family members of residents stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>Interpreter services can be accessed via the Waitemata District Health Board (WDHB) when required or through a translation and interpreting service which covers many languages Staff also represent different nationalities and can assist as needed.</p> <p>Staff were observed communicating effectively with residents and resident's family members. There was appropriate communication for the needs of all residents. Written information is available and sourced in alternative formats to suit the needs of specific residents when necessary.</p> <p>During the recent Covid-19 lockdown when families could not visit, communication to families or those with enduring power of attorney (EPOA) included video calls, video messaging and phone calls.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The quality and business plan which are reviewed annually outline the purpose, values, direction, strengths, weaknesses and opportunities and goals of the organisation. The documents sighted describe annual and longer term objectives and the associated operational plans. The updated quality plan for 2020 was sighted at the time of audit and this clearly reflects a person/family centred approach to service delivery.</p> <p>The key responsibilities for the manager who reports directly to the owner/director are outlined in the job description and an individual employment agreement. The manager has been in this role for fifteen years (15), is a registered nurse with a current annual practising certificate. The manager has attended all education provided at this facility, relevant education at the WDHB, attended an aged care conference in 2018 and also holds a current first aid certificate. When interviewed the manager and a registered nurse who supports the manager, confirmed knowledge with the sector, regulatory and reporting requirements.</p> <p>The service holds contracts with the Waitemata District Health Board (WDHB) for rest home, respite and secure dementia care services. Thirty four (34) residents were receiving services on the day of the audit including twenty (20) aged related residential care (ARRC) rest home level care, nil respite care, and fourteen (14) residents were receiving care in the dementia care unit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>FA</p>	<p>The organisation has a risk management plan that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular annual resident satisfaction survey, monitoring of outcomes, clinical incidents including any infections and wound care management. The last resident and family survey July 2019 showed that most areas of service are satisfactory and families reported they were pleased with the care their relatives were receiving.</p> <p>Any internal audit results are followed up to improve services as required. Staff interviewed reported their</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>involvement in quality and risk activities through the audit activities and the corrective action follow up as needed.</p> <p>The meeting minutes reviewed confirmed that regular management and staff meetings occurred on a monthly basis. Monthly findings reports sighted include internal audits completed, findings and improvements required and the corrective action report with the issue, action taken and the outcomes documented. Health and safety is also considered with falls, challenging behaviour, skin tears, medication errors and other general business. Records for three months were followed through and any highlighted areas were discussed at the monthly staff meetings. Good attendance at staff meetings was observed.</p> <p>Policies and procedures reviewed cover all the necessary aspects of service delivery and meet contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process in place. Policies are based on best practice and were current for this year 2020. The service continues to update policies with the manager being responsible for this role. All updated policies are discussed at the monthly staff meetings as per the minutes sighted. The document control system ensures a systematic and regular review process occurs ensuring all references are current and up to date. Any obsolete documents are removed from the system and stored appropriately.</p> <p>The manager interviewed described the processes for the identification, monitoring and development of mitigation strategies. The manager and the registered nurse are familiar with the Health and Safety at Work Act (2015) and all requirements are implemented. The hazard register is well maintained.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The manager interviewed and staff were fully informed of the obligations for incident/accident reporting. Staff reported that all adverse and near miss events are documented on the appropriate accident/incident form provided and that are always accessible when required. A sample of incident forms reviewed showed these were fully completed, incidents were investigated and action plans developed, implemented and followed-up in a timely manner. Adverse event data is collated, analysed and reported to the manager monthly using a detailed analysis report which covers falls, medical events, skin tears, wounds, bruises and near miss events. This information is presented and discussed at the staff meetings. This is confirmed by staff during the audit. Adverse event information is used to improve the service as appropriate and this is clearly documented.</p> <p>The manager described essential notification reporting requirements and advised that there has been no Section 31 notifications since the previous audit. There have been no other coroner's requests, police investigations, issues based audits and/or any other notifications known to the current manager.</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>	<p>FA</p>	<p>Human resource management policies and processes are based on good employment practice and when reviewed meet all relevant legislation. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are well maintained. The recruitment process includes referee checks are undertaken, police vetting and validation of qualifications and annual practising certificates (APCs) are checked for currency where required for all health professionals employed or contracted to this service.</p> <p>Staff orientation includes all necessary components relevant to each role. Staff interviewed reported that the orientation process prepared them for their role. Staff records show documentation of completed orientation and performance reviews annually. The annual reviews were up to date.</p> <p>Continuing education is planned on an annual basis and includes all mandatory training requirements. All staff education was clearly documented and each staff member has an individual training record showing what they have attended. Care staff have either completed or have commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the WDHB (this is reflected in the pay scales for the care givers of which five have completed Level 4, four level 3 (one additional care giver is paid as level 3 for long service and experience). Care staff are being encouraged to enrol in the 2021 programme. The activities coordinator has not completed the NZQA training as yet but has a diploma in recreation and sport. The senior care staff who work in the dementia service have all completed the appropriate training. The gerontology nurse specialist provides additional in-service training as arranged with the manager.</p> <p>The one registered nurse maintains the annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a staffing rationale policy and process for ensuring staffing levels and skill mixes to provide safe service provision 24 hours a day seven days a week (24/7). The coverage meets the requirements and obligations of the service agreement with WDHB. The facility is on one level which works well from a planning perspective. The manager adjusts staffing levels to meet the needs of the residents as required. An after-hours roster is in place with staff interviewed reporting that advice is available when required. The general practitioner (GP) was interviewed and spoke highly of the staff and resident care provided. Any instructions were always carried out appropriately.</p> <p>The caregivers interviewed reported that there were adequate staff on duty and that team work is encouraged. Staff were replaced for any unplanned leave. At least one staff member has a current first aid certificate on each duty. Observations and review of the rosters confirmed adequate coverage is provided. Resident and family/whanau interviewed supported this.</p>
<p>Standard 1.3.12: Medicine</p>	<p>FA</p>	<p>The medication management policies and procedures comply with the medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>practice complies with the medication management policy for the samples sighted. A safe system for medicine administration management was observed using blister packed medications on the day of the audit. The staff member observed demonstrated a good knowledge and a clear understanding of the role and responsibilities involved for each stage of medicine management. All staff who administer medicines complete annual competencies.</p> <p>The medications process is closely monitored by the RN and the manager who is an RN. The medications are checked by the RN when delivered to the facility by the contracted pharmacy. Pharmacist input is provided as requested by the RN and/or the GP.</p> <p>Controlled medications are not stored on site. The medication fridge is monitored daily. Good prescribing practices included the prescriber's signature, date and designation with registration number included. Discontinuation of medicines and all requirements for pro re nata (PRN) medicines are effectively met. The GP reviews all medication three monthly and this is recorded on the medication record and in the individual clinical records.</p> <p>There are no residents who self-administer medications at the time of the audit. Appropriate processes are in place to ensure this is managed safely if needed.</p> <p>Medication errors are reported to the RN or manager and recorded on an accident/incident form. There is a process for analysis of any medication errors and compliance with this process is verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>One cook assisted by a kitchen team prepares and cooks the meals at this facility. The menu follows seasonal patterns summer and winter and has been reviewed by a qualified dietitian within the last two years. The service has a food control plan. The food once prepared is transported for serving to residents in the dining lounge or as appropriate. Dietary requirements cultural and food preferences are accommodated. Dietary needs with resident likes and dislikes are included in the assessment completed by the RN at the time of admission with family/whanau input as needed. A copy is given to the Cook and a copy retained in the individual resident record. Additional snack food is also provided 24/7. The contracted dietitian can be contacted on a referral basis if advice is needed for a resident to meet their nutritional needs.</p> <p>Care givers were observed assisting the residents with their meal and drinks in the dining lounge. The cook interviewed reported that constant feedback from the residents and staff about meals is provided. Family members interviewed confirmed satisfaction with the meal service.</p> <p>All food service staff and kitchen staff received training on food safety, food handling and hand hygiene. Nutrition and safe food management policies and procedures define the requirements of all aspects of food safety including kitchen cleaning schedules and additional chores required on a daily basis. Special equipment to meet resident's nutritional needs is available.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Six sample resident records were reviewed four rest home and two dementia level care. All six long term care plan reviewed identified that the RN has undertaken all initial assessments, such as validated nursing assessments for falls risk, skin integrity, depression scale and the interRAI assessments. The RN is responsible for completing all interRAI assessments for this service. Developed comprehensive long term care plans within the required time frame. Short term care plans are developed and if not resolved transferred to long term care plan in the required time frame. The RN and allied health including the physiotherapy assessment, nutritional assessment are also completed as part of the admission process. The dietary requirements support resident preferences and choices of food. The activities coordinator completes the individual resident activities plan including resident activity selection and preferences.</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>When a residents condition changes the RN initiates a GP consultation. Staff stated they notify family members about any changes in the resident health status. Care plans sampled have interventions documented to meet the needs of the residents and there is documented evidence of care plans being updated with interRAI assessment outcomes being integrated into the care plan. Resident falls are reported on incident report forms and documented in the written progress notes. Neuro-observations are taken for all residents with unwitnessed falls. In addition the resident is reviewed by the GP and contracted physiotherapist to assess mobility. The RN uses a wound assessment tool if a wound or skin tear is sustained. There is list of current wounds stating what day wounds are due to be reviewed as planned. Monitoring forms in place and completed. There are six wounds on the day of audit as per the list sighted, two post-surgery followed by the surgeon at the WDHB post-surgical care team and four skin tears. There are no pressure injuries on the day of the audit and this was confirmed by the RN interviewed. There are adequate best practice resources for wound and continence management available if and when needed.</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</p>	FA	<p>There is one activities coordinator (Monday to Friday who facilitates the activities programme. Staff cover in the weekend and families often take residents that are able out for a drive or home. One caregiver has been trained with safe and simple activities to share in the weekend. Each activities plan is developed for each resident by the activities coordinator in conjunction with the RN and with the resident /family as appropriate. A holistic 24/7 approach to activities is available and includes aspects of the resident's life and past activities. This is especially important for those residents in the dementia service. Resources are available if needed in the night time. Rest home residents have choices as to whether to attend planned activities. A wide variety of activities provided that are appropriate to meet the needs of residents. Special events such as birthdays, Christmas and New Year are</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>celebrated. Participation is monitored. Outings in the community are encouraged with fortnightly van trips and community activities. Visitors from the community are welcome such as dance groups and music groups. Visits from school /kinder garden children are enjoyed as confirmed by the activity coordinator interview. Church services or other cultural practices are arranged as per individual/family information gained on admission. The residents' records reviewed have updated activity plans and the long term care plan is reviewed six monthly in consultation with the activities coordinator. Families are welcome to join in the activities and at interview were pleased with the activities provided in both the rest home and the dementia services.</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>Resident care is evaluated on each shift and documented in the progress records. If the care staff observe any changes it is reported to the RN.</p> <p>Care plan evaluations occur six monthly in conjunction with the interRAI re-assessment process or if there are any changes. The RN is responsible for all evaluations. If progress is different than expected the service responds by making changes to the care plan. Short term care plans are developed as necessary and consistently reviewed as clinically indicated. Other plans such as wound care plans are evaluated at the time the wound care is provided. Residents and families interviewed provided examples of their involvement in the care planning process. GP reviews are completed three monthly both medically and medications are also reviewed.</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>The environmental design provides safe areas that encourage purposeful walking this includes easy access to a safe outdoor area for those residents in the dementia and rest home services. The service has a current building warrant of fitness dated expiry 09 July 2021. This is framed and displayed in the entrance to the facility. The most recent fire drill was held on the 08 July 2020. Electrical and calibration checks are current and up-to-date.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p>	<p>FA</p>	<p>The RN is the Oronga rest home infection prevention and control coordinator. Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. Some infections include fungal, eye, gastro-intestinal, wound or soft tissue, upper and lower respiratory infections and skin infections are common. When an infection is identified by the care staff they document on the infection form and let the RN know in a timely manner. The RN reviews all infections reported. Monthly surveillance occurs and information is collated and analysed to identify any possible trends or causative</p>

<p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>factors and if any actions are required. The results are shared with staff via the staff meetings and at time of handover between the shifts. Graphs are used to display the results and measured against the previous months' results. Any new infections are discussed at the handover time so that any interventions can be actioned.</p> <p>The RN and care staff interviewed have a good understanding of infection prevention and control and standard precautions. Staff were fully informed about managing surveillance, including all precautionary measures for Covid 19. Records of residents, visitors and staff temperatures and/or other symptoms were recorded accurately as part of the surveillance programme.</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 service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents using a restraint on the day of the audit. There are two residents with voluntarily enabler aids for mobilisation and safety use only. All necessary assessments and documentation have been completed in relation to enabler use. Staff interviewed had a good understanding of restraint and enabler use and had received appropriate training. A registered nurse is the designated restraint coordinator and maintains the restraint register.</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.

No data to display

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.