

# Presbyterian Support Central - Kandahar Court

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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 BSI Group New Zealand Ltd, 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:** Presbyterian Support Central

**Premises audited:** Kandahar Court

**Services audited:** Dementia care

**Dates of audit:** Start date: 9 June 2021 End date: 10 June 2021

**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:** 29

# 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

Kandahar Court is part of the Presbyterian Support Central organisation. The service provides dementia level care for up to 29 residents. On the day of the audit there were 29 residents.

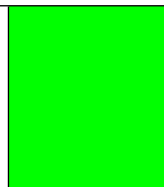
This unannounced surveillance audit was conducted against a subset of the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with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

The service is overseen by a non-clinical facility manager and a clinical nurse manager both of whom are well qualified and experienced for their roles. This management team also oversees Kandahar Home which is physically three minutes away. The facility manager and clinical nurse manager are supported by the clinical coordinator and registered and enrolled nurses. Family interviewed spoke positively about the service provided.

This audit did not identify any areas requiring 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.

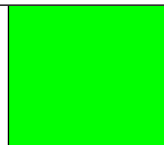


Standards applicable to this service fully attained.

Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Staff and relatives interviewed were familiar with the complaint's management process.

## 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.

Presbyterian Support Central Kandahar Court continues to implement the Presbyterian Support Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to monthly senior team meetings. An annual relative satisfaction survey is completed and there are regular family meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme for all roles within the service. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

## 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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Registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Electronic resident files included medical notes by the general practitioner, nurse practitioner and visiting allied health professionals. There is a three-monthly nurse practitioner or general practitioner review.

The residents' activities programme provides diversional therapy activities, these include one-to-one and group activities, community involvement and outings.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete annual education and medication competencies. All medication charts have photo identification, allergy status and evidence of three-monthly reviews noted.

All meals are prepared and cooked at Presbyterian Support Central Kandahar Home and transported to Presbyterian Support Central Kandahar Court. There is a Food Control Plan in place. The five-weekly seasonal menu is under review by a dietitian. Individual and special dietary needs and residents' dislikes are catered for, and alternative options are available for residents.

## 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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Presbyterian Support Central Kandahar Court has a current building warrant of fitness.

## 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 is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. Other than the environmental restraint of the secure unit, no restraint or enablers are used. Staff are trained in what restraint is and challenging behaviour management.

## 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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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification

and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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	17	0	0	0	0	0
<b>Criteria</b>	0	46	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)
<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>	FA	<p>There is a complaints policy to guide practice, and this is communicated to family members/representatives. The facility manager leads the investigation and management of complaints (verbal and written). A complaint's register records activity. Complaint forms are available at the front entrance. Two complaints have been made since July 2019 and 2021 year to date. The first complaint reviewed was appropriately investigated and resolved to the satisfaction of the complainant, any corrective actions identified were implemented. The second (recent complaint) had been resolved but a report to the senior management team meeting was still to occur in early June. Discussion with relatives confirmed they were aware of how to make a complaint. A copy of the complaint's procedure is provided to relatives within the information pack at entry.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is an open disclosure policy. The four relatives interviewed stated they were welcomed on entry with their family member and were given time and explanation about the services and procedures. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Ten incident forms randomly selected over four months in 2021 identified family were notified following a resident incident. Interviews with healthcare assistants confirmed family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Family is invited to three monthly reviews and relative meetings occur six-monthly.</p>



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>Kandahar Court is part of the Presbyterian Support Central (PSC) organisation. The service provides dementia level of care for up to 29 residents. On the day of the audit there were 29 residents; one resident was on a long-term chronic health condition contract and the remainder were all on the Aged Related Residential Care (ARRC) contract.</p> <p>There is a non-clinical manager who has been in the position for four and a half years. There is a clinical nurse manager (five years in the role) and a clinical coordinator who provides support to the facility manager. The manager and clinical nurse manager also oversee the sister home – Kandahar Home, which is three minutes away from Kandahar Court. The clinical coordinator at Kandahar Court is fulltime. The manager and clinical nurse manager are each at the site a day a week and as required. The manager also undertakes work for the site whilst based in his office at Kandahar Home.</p> <p>The clinical coordinator (based at Kandahar Court) has worked at the service for ten years. The clinical coordinator from Kandahar Home also covers Kandahar Court for some on call and as the Infection Prevention and Control (IPC) coordinator.</p> <p>Kandahar Court has a 2020-2021 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, the Eden alternative and health and safety. Progress towards goals (and objectives) is reported through the manager reports taken to the monthly senior management team meeting.</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>Presbyterian Support Central has an overall Quality Monitoring Programme (QMP) and Kandahar Court participates in the PSC benchmarking programme. The senior team meeting acts as the quality committee and they meet monthly. Information is fed to the monthly clinical focused meetings and staff meetings. The meetings are combined with meetings alternating between the sites (Kandahar Court and Home). There is an annual meeting schedule including staff (full facility) meetings. Staff meetings are held monthly. Meeting minutes and reports are provided to the senior team meeting, actions are identified in minutes and quality improvement forms. The facility manager had an understanding of the contractual agreements and requirements.</p> <p>Progress with the quality programme/goals has been monitored and reviewed through the twice monthly senior team meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2021 (year to date). Data is collected in relation to a variety of quality activities, including accidents/incidents, falls and infection control. There is discussion around quality data trend analysis at staff meetings (and at handovers) along with progress in corrective action plans. The PSC organisation oversees minutes, corrective action plans and progress. The service has a health and safety management system, and this includes health and safety representatives (clinical and non-clinical that are undertaking or have completed health and safety training). Monthly reports are</p>

		<p>completed and reported to meetings and at the quarterly health and safety committee. Health and safety meetings include identification of hazards and accident/incident reporting and trends.</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from central office. Policies and procedures are introduced to staff ensuring staff are kept up to date with the changes. An organisational staff training programme is based around policies and procedures. A relative satisfaction survey is completed annually. The 2020 survey informed an overall satisfaction with the service in line with PSC average, however only 1 out of 29 relatives responded. Some information from relatives was gained from relatives at meetings and on 1:1 communication. The responses were positive. The 2021 relative survey is due to be sent out September 2021.</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 service collects a set of data relating to adverse, unplanned and untoward events. The data is linked to the service benchmarking programme and this is used for comparative purposes with other similar PSC services. Ten incident forms (randomly selected for the period January to May 2021) for Kandahar Court were sampled. All incident forms have been fully completed and residents reviewed by a registered nurse. There is documented evidence of relative notification (or documentation that relatives do not wish to be informed, eg, if it is a fall with no injury) on all nine accident/incident forms involving residents. The tenth event related to a medication error. Discussions with management confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A section 31 notice was made concerning the loss or RNs to DHB employment.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. A copy of qualifications and annual practising certificates including registered nurses, dietitian and other registered health professionals are kept. Six staff files were reviewed (one clinical nurse manager, one clinical coordinator, one enrolled nurse, one healthcare assistant, one recreational officer and one cleaner). All but one staff file reviewed included the appropriate employment and recruitment documents including annual performance appraisals if due (four not were not due). There had been a corrective action within the internal audit programme to ensure a</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>schedule for compliance with annual staff appraisals occurred.</p> <p>The clinical coordinator and the clinical nurse manager are interRAI trained.</p> <p>The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. A training programme is in place that includes eight hours of annual education. The registered and enrolled nurses attend PSC clinical and professional study days, which cover the mandatory education requirements and other clinical requirements. Attendance is monitored. The staff training plan includes regular sessions occurring as per the monthly calendar. Eighteen of twenty-three healthcare assistants who are employed in the dementia care unit have completed their dementia specific units. One other is in progress and four are enrolled.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager, clinical nurse manager and clinical coordinator work full-time. There is a registered nurse on daily (including the clinical coordinator for eight hours, seven days a week). For two days a week there are two RNs on. Agency staff are used to provide cover for sickness if necessary. The health care assistants (HCA )numbers are adequate. Interviews with HCAs and family members identified that staffing is adequate to meet the needs of residents. Staff levels and skill mix are meeting contract and industry norm requirements.</p> <p>There are at least four HCAs/ENs on the AM, four on PM shifts and two on the night shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The medication trolley is securely locked along with medication in cupboards in a locked office. The room temperature and medication fridge temperature are monitored.</p> <p>Registered nurses, the enrolled nurse and/or medication competent carers administer medications from robotic rolls on medication rounds. These staff have been assessed for competency to administer and/or check medication on an annual basis and receive annual medication education. All medication is checked on delivery against the electronic medication chart. All medications were securely and appropriately stored. There were no residents self-medicating. All eye drops, and ointments were dated on opening.</p> <p>Ten medication charts reviewed met legislative requirements; all charts had photo identification and allergies/adverse reactions noted, and 'as required' medications prescribed correctly with indications for use. Medications had been signed as administered in line with medication charts. The ten medication charts included three monthly GP/NP reviews. Appropriate practice was demonstrated on the witnessed medication round. Controlled medication administration was fully documented.</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>All meals are prepared and cooked at PSC Kandahar Home. Daily hot food temperatures are taken and recorded for each meal. All meals are cooked and transferred to a bain marie. Meals are then put in a hot box and transported to Kandahar Court where meals are served to residents in the dining room or delivered on trays to residents in their rooms.</p> <p>The kitchen at Kandahar Home was observed. The Food Control Plan expires on 23 January 2022. The food services team leader at Kandahar Home (a qualified cook), is responsible for the operations of food services. The kitchen team includes the food services team leader and two kitchenhands. There is a five weekly rotating summer and winter menu that is currently under review by the company dietitian (previous review July 2019). A food services policies and procedures manual is in place.</p> <p>All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The cook has access to the electronic patient management system and maintains a list of residents' dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. Snacks are available for residents 24 hours a day.</p> <p>Food surveys provide relative feedback on the meals and food services. Relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered.</p> <p>Fridge and freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date-labelled and stored correctly. The kitchen has a dishwashing area, preparation, cooking, baking and storage areas.</p> <p>Chemicals are stored safely. Safety data sheets are available, and training is provided as required. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.</p> <p>The main meal is served at 1700 hours as opposed to midday. The change was made eighteen months previously and staff commented on the positive aspects of this.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services</p>	<p>FA</p>	<p>A health status summary held in the resident's electronic records documents significant events, investigations, GP visits and outcomes. The registered nurse initiates a review when there is a change in the resident's condition and arranges a GP or nurse specialist visit if required. There is evidence of three-monthly medical reviews, or the GP/NP and they will visit earlier if there is a change in health status. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to residents' health status. Resident files sampled recorded communication with family.</p>

<p>in order to meet their assessed needs and desired outcomes.</p>		<p>Staff reported there were adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. There were also adequate supplies of linen sighted.</p> <p>There were three wounds and no pressure injuries being treated on the day of the audit. All three wounds were fully reviewed. Wound assessments had been completed; all wounds had individualised plans which were being followed. There was evidence of NP and GP involvement and/or wound specialist nurse input. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>HCA's are alerted to the requirement to complete electronic daily monitoring and advised of specific resident needs at handovers. The active short-term care plans and long-term care plans are in the electronic resident care system. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts are completed 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 recreation team leader (based at Kandahar Home), that oversees activities in Kandahar Court, and two fulltime recreation officers based at Kandahar Court both of whom are qualified diversional therapists.</p> <p>The recreations staff hours are Monday to Friday and periodically the weekends. After hours the healthcare assistants have activities, they access to provide activities for residents.</p> <p>A chaplain also provides spiritual and pastoral care to residents.</p> <p>The activities programme is displayed on a weekly calendar. It includes (but is not limited to) whiteboard games, crafts, reminiscing games, dominos, golf, music, ball handling, van outings, twice weekly visits from school children, baking, sing-a-longs and church services. There are regular outings into the community with the recreation officers who each have a first aid certificate.</p> <p>There is a range of activities to meet the recreational preferences and individual abilities of residents. One-on-one time is spent with residents who choose not to participate in the group programme.</p> <p>The recreation officers complete a resident social profile and activities assessment and in conjunction with the RN they write the 24/7 activities plans in resident files on admission. Attendance records and progress notes are maintained. Each resident's activity plan is reviewed six-monthly. The relatives provide feedback on the programme through one-to-one feedback. The residents were sighted on the day of the audit participating in activities and relatives interviewed commented positively on activities offered.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>Two of the five residents' files sampled had been in the facility for longer than two years. There was evidence in these files of evaluations of the support plan. There was at least a three-monthly review by the GP/NP. Care plan</p>

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		reviews by the RN were evident in files sampled.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current building warrant of fitness which expires 1 July 2021. The facility has a budget that allows for the ongoing maintenance and replacement of equipment and furnishings. It was evident on audit that this had been utilised: for example there was an adequate supply of fresh linen.
Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations.	FA	Click here to enter text
Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs at Kandahar Court. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and laboratory staff that advise and provide feedback/information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the senior management/team leader and staff meetings. The senior management/team leader meetings include the monthly infection control report. Individual resident infection control summaries are maintained. All infections are documented on the infection monthly online register. The surveillance of infection data assists in evaluating compliance with infection control practices. Short-term care plans were evidenced as completed for infections. There have been no outbreaks reported since previous audit.

control programme.		Covid 19 education and training programmes for all staff have been completed including use of personal protective equipment with the last session being completed in June 2021.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has a restraint minimisation and safe practice policy in place. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Other than the environmental restraint of a secure unit, nil restraint is used.</p> <p>Staff are trained in what restraint is, challenging behaviour and de-escalation and competencies are completed.</p>

## Specific results for criterion where corrective actions are required

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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
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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.

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End of the report.