

Living Waters Medical Solutions Limited - Virginia Lodge

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: Living Waters Medical Solutions Limited

Premises audited: Virginia Lodge

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 7 October 2021 End date: 8 October 2021

Proposed changes to current services (if any): The service has changed the facility name from Virginia Lodge to Living Waters

Total beds occupied across all premises included in the audit on the first day of the audit: 18

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

Living Waters (previously named Virginia Lodge) provides rest home level care for up to 21 residents. On the day of the audit there were 18 residents.

The unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, general practitioner, staff, and management.

The service is managed by a non-clinical manager who has extensive management experience (not in aged care) and a clinical nurse manager who is experienced in aged care. Residents and relatives interviewed were complimentary of the service provided.

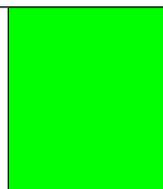
There are quality systems and processes in place that have carried over from the previous owner and have been appropriately reviewed. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

There were no areas for improvement identified at the previous provisional audit.

There were no areas for improvement identified as required at this surveillance audit.

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.

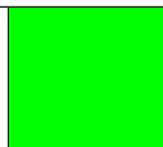


Standards applicable to this service fully attained.

The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers Rights (the Code). Information about the Code and related services is readily available to residents and families. Complaints processes are implemented, and complaints and concerns managed and documented.

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.

Living Waters Rest Home has an embedded quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to regular meetings including the monthly staff meetings. Surveys and now 6 weekly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections, and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

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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Assessments, resident-centred care plans and evaluations were completed by the registered nurse within the required timeframes. Risk assessment tools and monitoring forms are available and implemented. Resident-centred care plans were individualised and reflected allied health involvement in the resident's care.

With the support of caregivers the diversional therapist coordinates and implements a five-day a week activity programme. The activities meet the individual recreational needs and preferences of the residents. There are outings in the community and visiting entertainers and pet therapy.

There are medicine management policies in place that meet legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three-monthly.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with nutritional guidelines. Residents commented very positively on the meals provided.

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 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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. There were no residents with restraint or using an enabler. Staff receive education and training on restraint minimisation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control officer (the clinical nurse manager) with support of an infection control committee, uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There have been no outbreaks. A pandemic plan was actioned, and Covid-19 policies and procedures have been developed and implemented. Living Waters Rest Home adheres to current MoH and DHB Covid-19 guidelines and recommendations.

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	16	0	0	0	0	0
Criteria	0	41	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>Complaints forms are available at the front entrance to the facility and there is a receptacle to receive them. Information around the complaints process is provided on admission and is included in the admission pack. A record of all complaints, both verbal and written would be maintained by the facility manager on the complaints register.</p> <p>Nil complaints have been received since the new owners/management commenced 22 March 2021. Management were able to verbalise the process should a complaint be received. Staff interviewed confirmed that previously, complaints and any required follow-up is discussed at staff meetings and they understood this process was to remain. Residents and relatives advised that they are aware of the complaints procedure and how to access forms.</p> <p>There were no complaints lodged by any external authority since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Five residents and three relatives interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry. The manager (non-clinical) and clinical nurse manager (RN) operate an open-door policy. Ten incident/accident forms reviewed from September identified that the next of kin (NOK) were notified following a resident incident unless they had recorded, they did not wish to receive notification (the situation in one incident).</p> <p>The manager, clinical nurse manager and caregivers (5) interviewed confirmed relatives are kept informed. The</p>

<p>environment conducive to effective communication.</p>		<p>following staff were also interviewed during the audit: the cook, general practitioner (GP) and diversional therapist (DT). The relatives interviewed confirmed they are notified promptly of any incidents/accidents. Families are invited to attend the resident meetings. Interpreter services are available if required.</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>Living Waters Rest Home (referred to in the report as Living Waters) provides care for up to 21 rest home level residents. There were 18 residents on the day of the audit including one resident on an intermediate care contract, and two residents on a Ministry of Health (MOH) younger person contract.</p> <p>Living Waters quality and business plan includes the mission, philosophy, quality, and policy statement. Aims and ambitions for the coming year included achieving full occupancy of permanent residents, achieving an 'A' grade food control plan (achieved), the service has purchased a 'chair raiser' which safely lifts residents off the floor. Aims and ambitions which are ongoing include, the facility remaining Covid-19 free, and the refurbishment of the facility. To date a new furnace system has been installed and new lighting (this was interrupted by Covid and is to be completed as soon as possible). The quality goals are reviewed regularly at the combined quality/staff meetings and are signed off when completed.</p> <p>The current owners who also own a medical centre, took over the business fully in March 2021. One of the owners is a general practitioner and provides coverage to the home. The manager (non-clinical) has held management roles in health (DHB), the prison service and is also a Medical Practice Manager. The manager is responsible for the day to day running of the facility and meets or is in contact with the GP/owner almost daily. The manager is supported by the clinical nurse manager (registered nurse) who has worked in aged care for eleven years. The CNM is undertaking postgraduate studies. At present the facility is seeking another registered nurse. At present the GP owner shares clinical "on call" with the CNM.</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</p>	<p>FA</p>	<p>Living Waters is implementing a quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. These are checked by an aged care consultant, who reviews policies to ensure they align with current good practice and meet legislative requirements.</p> <p>An internal audit programme is in place that includes aspects of clinical care. Issues arising from internal audits are either resolved at the time or developed into a quality improvement plan. The closure of corrective actions resulting from the internal audit programme was recorded, signed off by the clinical nurse manager (if clinical) and the manager and signed by staff who were not present at the meeting. A record of monthly risk identification, and quality indicators is maintained and discussed at the monthly meetings and a copy is filed with the completed monthly internal audits. Quality/staff and resident meeting minutes include a detailed account of the discussion/outcomes of</p>

principles.		<p>the meetings, including follow-up to actions taken as matters arising.</p> <p>To date, a relative satisfaction survey (completed in September 2021) covering welcome, cleanliness, actioning of requests, respect, dignity, privacy, care, being kept informed, safe during lockdown, communication during lockdown, laundry, food, hairdressing, and the approachability of management had been undertaken with 100% satisfaction and very positive comments. There was a response rate of 50%. To date a resident survey covering qualified staff had been undertaken with positive results. Since April 2021 sixteen audits covering various aspects of the service had been undertaken. All scored above 91% and follow-up actions have been undertaken and signed off.</p> <p>The risk management plan is in place. The manager is the health and safety officer. Staff receive health and safety training during orientation and ongoing. Health and safety is discussed and documented in the monthly quality/staff meetings. Actual and potential risks are documented on the hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. The register is up-to-date and on audit there was evidence of systems being actioned. Falls management strategies were in place and the new management had introduced a post-fall assessment form.</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>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted including any follow-up action(s) required. Incident/accident data is linked to the home's quality and risk management programme. Ten accident/incident forms were reviewed with each incident involving a resident clinical assessment and follow-up by a registered nurse. Neurologic observations were conducted for suspected head injuries, and opportunities to minimise future risks were identified and implemented.</p> <p>The manager and CNM reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. The one notification made since taking over the home was to MOH regarding change of name.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	FA	<p>There are human resources policies to support recruitment practices. Five staff files sampled (one clinical nurse manager, two caregivers (one recently employed), one diversional therapist and one cook) contained all relevant employment documentation. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience, and suitability for the role. Performance appraisals were</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>current. Current practising certificates were sighted.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. An annual training programme covering all the relevant requirements is implemented. Attendance records evidenced good attendance at education. Staff have the opportunity to attend external education. Clinical staff complete competencies relevant to their role, including medication competencies, manual handling, restraint, pain, culture, hydration and nutrition, infection control, health and safety and wound care. Thirteen staff have current first aid certificates with upcoming training for two more.</p> <p>Currently there are four caregivers with New Zealand Qualification Authority (NZQA) level 4, two with level 3 and two currently working on it, three with level 2 and two with level 1. The kitchen staff have food handling certificates.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Living Waters 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 manager and clinical nurse manager work Monday to Friday and share all calls (the GP covers clinical calls, as required, if the non-clinical manager is on call).</p> <p>They are supported by three caregivers in the morning; one from 7 am to 3 pm, one from 7 am to 11 am and 1 x 7.30 am to 1.30 pm; this shift can be extended when acuity of residents is higher.</p> <p>Three caregivers work in the afternoon shift: 1 from 3 pm to 8 pm, 1 from 5 pm to 7 pm and 1 from 4 pm to midnight. One caregiver works from midnight to 8 am.</p> <p>Interviews with the CNM, caregivers and residents confirmed that there are sufficient staff to meet care needs.</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 CNM and senior caregivers who administer medications complete annual medication competencies and education on medication is provided. The medication storage areas are secure. Medications (blister packs) are checked on delivery by the RN against the electronic medication chart and verified on the medication system. Any discrepancies are fed back to the pharmacy. Standing orders are not used. There were no self-medicating residents. The medication fridge is monitored each night. The medication room air (nurses' station) is monitored daily. All eyedrops were dated on opening.</p> <p>Ten medication charts were reviewed on the electronic medication system. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three-monthly. 'As required' medications had indications for use and administered as prescribed. The effectiveness of as required medications was documented in the electronic medication system.</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>Meals are prepared in a well-appointed, homely open plan kitchen adjacent to the dining room and served directly to the residents. The head cook works from Wednesday to Sunday from 8 am to 2 pm. She is supported by a second cook on Mondays and Tuesdays. Food services staff have attended food safety and chemical safety training. The six weekly menus have been reviewed by a registered dietitian (August 2019). Pureed/soft diets are provided. The cook receives a dietary profile for all residents. Dislikes are accommodated. The main meal is at midday. A caregiver on afternoon duty heats and serves the pre-prepared dinner meal. Lip plates are provided as required.</p> <p>The service has a current food control plan expiring 2022. Fridge, freezer, and chiller temperatures are monitored and recorded daily. End-cooked temperatures are taken on all meats and recorded.</p> <p>All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained. Chemicals are stored safely.</p> <p>Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were very satisfied with the meals provided.</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, a registered nurse initiates a review and if required, GP, nurse practitioner or nurse specialist consultation. There is documented evidence on the family contact form in each resident file that indicates family were notified of any changes to their relative's health. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in the nurse's station/treatment room. Wound management policies and procedures are in place. Wound assessment (including photographs) and treatment forms, ongoing evaluation form and evaluation notes were in place for three residents with wounds. There were no pressure injuries on the day of audit. There is access to a wound nurse specialist at the DHB.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Monitoring forms are used for weight, pulse, temperature and blood pressure recordings, neurological observations, pain, challenging behaviour, food, and fluid charts.</p>
<p>Standard 1.3.7: Planned Activities Where specified as</p>	<p>FA</p>	<p>The service employs a qualified diversional therapist (DT) who works a minimum of 18 hours per week, Monday to Friday. This is an increase of 5.5 hours per week. She has a support network through the DT Society and on-line DT groups. The DT makes daily contact with all residents and one-on-one activities such as individual walks, reading</p>

<p>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>and chats occur for residents who choose not to be involved in group activities. Care staff follow the DT guide for afternoon and weekend activities. There are plentiful resources available.</p> <p>The monthly programme is developed in consultation with the manager and from resident feedback at the six weekly meetings. The programme is varied and meets the physical and psychosocial well-being of the residents. The programme includes board games, quizzes, colouring, poetry, newspaper reading, reminiscing, gardening, walks and happy hour. Community visitors include entertainers, visiting pets and farm animals, South Pasifika college students, ukulele club. There are monthly non-denominational services and weekly communion. Festive occasions and themes are celebrated. Families are invited to attend events. During lockdown some of the events have been cancelled or postponed and these have been replaced with others.</p> <p>The service hires a 10-seater van for monthly outings, scenic drives, and picnics. The DT has a current first aid certificate.</p> <p>A diversional therapy assessment, map of life and DT plan is completed within two weeks of admission. Individual activity plans were seen in long-term resident files. They are reviewed in discussion with the CNM and families every six months.</p> <p>The service receives feedback and suggestions for the programme through six weekly resident meetings, surveys and direct feedback from residents and families.</p> <p>There was positive feedback from residents and families about the activities programme in which they have input.</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 an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN six monthly, using the interRAI tool or earlier for any health changes. 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. Short term or specific care plans were updated and/or transferred to long term care plans. Care plans had been updated with any changes to health.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 22 June 2022.</p> <p>The new owner is focussed on undertaking maintenance (to date new furnace and new lighting) and has no plans for making environmental changes to the home.</p> <p>The physical environment minimises risk of harm, promotes safe mobility, including access to attractive outside areas, aids independence and is appropriate to the needs of the consumer/group'. All compliance issues are addressed including testing and tagging of equipment and fire evacuation drills.</p>

facilities that are fit for their purpose.		
<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>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. Systems in place are appropriate to the size and complexity of the facility (policies were reviewed August 2021). The infection control coordinator (the CNM who commenced in March 2021 who in previous positions has undertaken infection control training and is about to undertake education specific to the ICC role) collates information obtained through surveillance to determine infection control activities and education needs in the facility. There is an infection control committee consisting of the manager, CNM, kitchen representative, diversional therapist, and a caregiver. Infection control data is discussed at the combined quality/staff meetings. Data and graphs of infection events are available to staff. The CNM completes monthly and annual comparisons of infection rates for types of infections and will do an annual analysis of infections. Trends are identified and analysed, and preventative measures put in place. The local DHB ICC is available for advice and information and MOH guidelines are followed in relation to Covid. There were thorough Covid screening and controlled visitor systems in place on audit and in-service IC education/toolbox talks had increased to monthly to ensure all staff were aware of their responsibilities in relation to Covid and to learn necessary skills (e.g., donning and doffing of personal protective equipment).</p> <p>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>	FA	<p>There is a restraint minimisation and safe practice policy that is applicable to the service (reviewed July 2021). The clinical nurse manager holds the restraint coordinator position and has a job description in place. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint/enabler and challenging behaviour training has been provided annually. The latest training was August 2021 and 14 staff attended. Caregivers interviewed could fluently describe the differences between restraint and enablers and procedures around these</p> <p>There are currently no residents using restraint or enablers at Living Waters.</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.