

# The Coast to Coast Hauora Trust - Heritage Rest Home

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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 The DAA Group 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:** The Coast to Coast Hauora Trust

**Premises audited:** Heritage Rest home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 31 October 2017 End date: 31 October 2017

**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:** 10

# 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  |
|-----------|--|---|
|           | 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

Heritage Rest Home provides rest home level care for up to 17 residents. The service is operated by a board of trustees and managed by a chief executive office and a clinical nurse manager. Residents spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services 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 files, observations and interviews with residents, management, staff and two general practitioners.

There were no areas requiring improvement that needed to be followed up from the previous certification audit. This audit has identified no areas that required improvements to be addressed in the criteria audited.

## Consumer rights

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| 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. Staff provide residents and families with the information they need to make informed choices and give consent.

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

## Organisational management

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| 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, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility with the board of directors (the board) having governance oversight.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standards applicable to this service fully attained.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files sampled demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis.

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 assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals. There are renovations planned for the kitchen.

## 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.

A current building warrant of fitness is publicly displayed.

## 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.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. One restraint was in use. Policy states the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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.

Aged care 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                           | 16                  | 0  | 0                                    | 0  | 0                                      | 0  |
| Criteria          | 0                           | 39                  | 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   |
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| Standard 1.1.13: Complaints Management<br><br>The right of the consumer to make a complaint is understood, respected, and upheld. | 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 residents interviewed knew the process to follow. No negative comments were received from residents on the day of audit.</p> <p>The complaints register reviewed showed that three complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. One example sighted showed the follow up to a complaint involved staff training being put in place related to continence and catheter care and managing challenging behaviour. This was presented by the gerontology nurse specialist. More frequent GP visits were organised and changes were made to the daily handover between shifts. This now includes discussion between staff to clearly identify any resident non-compliance issues.</p> <p>The clinical nurse manager liaises with the chief executive officer (CEO) for all complaints and is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. At the time of audit there are no open complaints.</p> <p>There have been no complaints received from external sources since the previous audit.</p> |



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| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents stated they were kept well informed about any changes to their health status and that family were informed 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 on the communication sheets located in their files.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Management know how to access interpreter services, although they reported this was rarely required due to all residents being able to speak English. Staff confirmed that communication with residents has not been an issue to date.</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> | FA | <p>The business plan and quality plan, which are reviewed annually at board level, outline the purpose, values, scope, mission statement, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the board of directors from the chief executive officer (CEO) showed adequate information to monitor performance is reported including risk management, incidents and accident, health and safety, quality data as appropriate, cleaning, complaints, falls rates, staffing, behavioural issues, and resident satisfaction results. Two members of the board were interviewed and confirmed they are regular visitors to the facility and are fully aware of any issues that arise.</p> <p>The clinical nurse manager reports to the CEO monthly on maintenance, audit updates and outcomes, resident feedback from resident meetings, complaints, suppliers, clinical issues, staff meeting issues, staff competencies, new planned developments, quality data and corrective actions.</p> <p>Whilst the board of seven trustees oversee all governance issues, the CEO, who has been in the role for over 10 years, oversees all service provision of the facility. The clinical nurse manager (registered nurse) oversees the day to day clinical care services and has been in the role for six years. The clinical nurse manager holds relevant qualifications and actively undertakes ongoing education related to the role covering both clinical and management training. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The clinical nurse manager and CEO confirmed their knowledge of the sector, regulatory and reporting requirements. Evidence of an infectious outbreak reporting was sighted.</p> <p>The service holds a contract with Waitemata District Health Board (WDHB) for rest home level care and the Accident Compensation Corporation (ACC). Nine residents were receiving services under the Age Related Residential contract with the WDHB and one resident receives services under the Residential Support Client Specific contract with ACC at the time of audit.</p> |
| Standard 1.2.3: Quality   | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality  |

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| <p>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> |           | <p>improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and wound care. All quality data is trended against previously collected data. The internal auditing system is used to measure achievement against quality and risk management plans, and the board are made aware of outcomes.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality meetings, staff meetings and with the board as required. Staff reported their involvement in quality and risk management activities through audit activities and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. For example, following the June 2017 internal audit of medications an additional teaching session was put in place related to the signing of pro re nata (PRN) medication. This was re-audited in July with a 100% rating gained.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey showed that 2017 results reflected the most positive response in the last five years. One improvement has been made following a remark made on the satisfaction survey about communal toilet areas. Hourly checks are now being undertaken of toilet areas to ensure they are always clean. Resident interviews confirmed that they are happy to take part in the annual survey and that any issues raised, including at the resident meetings, are always dealt with promptly.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The process for policy review and development involves the clinical nurse manager, the CEO and board. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. All staff have computer access to the current policies which are kept in a shared folder.</p> <p>Two members of the board, the CEO and the clinical nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. All members of management are familiar with the Health and Safety at Work Act (2015) and the organisation has implemented requirements. These are reflected in the health and safety documents sighted. A health and safety audit is undertaken every three months which includes monitoring the effectiveness of the mitigation strategies shown in the hazard register.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>   | <p>FA</p> | <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. For example, one resident who has a high risk of falls has a shoulder alarm monitor in place. Adverse event data is collated, analysed and reported to the CEO and the board. Information is shared at monthly staff meetings.</p> <p>The clinical nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification to public health related to a norovirus outbreak in April 2016. There</p>  |

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| recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.   |    | have been no police investigations, coroner's inquests, or issues based audits since the previous audit.  |
| <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> | FA | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period. Annual staff appraisals are up to date.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff education is undertaken on-site and off-site with input from the WDHB gerontology nurse specialist at least three monthly. Four caregivers are registered to undertake ongoing approved gerontology education via the New Zealand Tertiary Collage as confirmed in documentation sighted and during staff interviews.</p> <p>The clinical nurse manager is a trained and competent registered nurse who maintains their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. They also attend New Zealand Nurses' Organisation gerontology group educational days.</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</p>                  | FA | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Care staff undertake laundry and cleaning duties as part of their daily tasks. Residents interviewed supported this. Observations and review of four weeks rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. InterRAI identifies all residents are rest home level care and staffing numbers are appropriate. At least one staff member on duty has a current first aid certificate. There are dedicated activities coordinator hours five hours a week, and kitchen staff seven days a week.</p>  |

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| providers.  |    | The clinical nurse manager works 21 hours per week over three days (Monday, Tuesday and Friday).  |
| <p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | FA | <p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The standing orders comply with legislation.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request, with all residents having a pharmacological review in 2017.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the fridge that contains the medicines are within the recommended range. There are no vaccinations or other medications that require a cold chain process to be implemented. No medications currently require refrigeration.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines are met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines.</p> <p>There are no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for analysis of any medication errors, with these forming part of the key performance indicators and quality reporting processes.</p> |
| <p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs</p>   | FA | <p>The food service is provided on site by the kitchen team. The menu has been reviewed and audited in 2017 by a dietitian which is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns on a four-week rotational menu.</p> <p>The kitchen is showing signs of wear and tear, with the service implementing a plan to refurbish the kitchen. The re-development is planned as soon as the trades people are available.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply</p>  |

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| are met where this service is a component of service delivery.  |    | <p>with current legislation and guidelines. The service does not yet have an approved food safety plan, with the development of this schedule for after the kitchen redevelopment. Food and storage temperatures are monitored weekly. The kitchen staff have undertaken relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile is developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. The resident expressed high praise for the food services with comments such as the food is 'like a five-star restaurant'.</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. All resident interviewed had high praise for the quality of care and service delivery at Heritage Rest Home.</p> <p>The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GPs interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and that the residents are receiving appropriate care. Caregivers confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>   |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The activities programme is provided by an activities coordinator or caregivers that are specifically rostered for assisting with the activities.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual and group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interesting.</p>   |

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| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | FA | <p>Resident care is evaluated on each shift on the 24-hour record of care and reported in the progress notes when there are significant changes. If any change is noted, it is reported to the RN. The RN makes entries in the progress notes at least weekly.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and use of short term care plans. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for wounds management and falls minimisation. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>                              | FA | <p>A current building warrant of fitness (expiry date 30 June 2018) is publicly displayed. There have been no changes to the facility footprint since the previous audit.</p>   |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The RN is the infection prevention coordinator and reviews all reported infections. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the trust through monthly management reports.</p> <p>A summary report for a recent gastrointestinal infection outbreak in April/May 2016 was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented regarding the cleaning of commode chairs.</p> |
| <p>Standard 2.1.1:</p>  | FA | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator, the clinical nurse</p>  |

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| <p>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> |  | <p>manager, provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, one resident was using a bedside rail restraint. No residents were using enablers. Policy identifies that enablers were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> |
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## 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.

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| 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.