

Patrick Ferry House Limited - Patrick Ferry House

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Patrick Ferry House Limited

Premises audited: Patrick Ferry House

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 14 February 2019 End date: 14 February 2019

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: 68

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Patrick Ferry House provides rest home and hospital (geriatric and medical) level care for up to 74 residents with an occupancy of 68 residents on the day of audit.

This 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 a review of policies and procedures; a review of residents and staff files; observations; and interviews with residents, family, management, staff and a general practitioner.

The hospital manager is supported by head office staff including the general manager with a clinical manager providing oversight of clinical care.

Both of the two corrective actions identified at the previous audit have been addressed. These were to corrective action plans and completion of interRAI assessments in a timely manner.

There are no further areas for improvement identified in this 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.

Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed they are provided with adequate information and that communication is open.

Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints with these investigated in a timely manner. A register of complaints is kept.

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.

There is a hospital manager, clinical manager and clinical coordinator who provide operational management and clinical management for the service.

There is an implemented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by the hospital manager. All aspects of the quality programme are discussed at relevant meetings. The health and safety programme is implemented.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An annual staff education and training plan is well attended with all staff attending mandatory training as required. Registered

nursing cover is provided on a morning, afternoon and night shift, seven days a week, with adequate numbers of care staff on each floor.

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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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate. They are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

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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There is 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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Staff regularly receive training around restraint minimisation and the management of challenging behaviour. There are nine restraints in use (bedrails and lap belts) and three enablers used in the service currently (bedrails).

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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A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of complaints. There are complaint forms available. Information about complaints is provided on admission. Interview with residents and families demonstrated an understanding of the complaints process. All staff interviewed could describe the process around reporting complaints. Discussions with residents and families confirmed that their issues are addressed, and they feel comfortable to bring up any concerns.</p> <p>There is a complaint register. Verbal and written complaints are documented. There have been 24 low level complaints in 2018 and none in 2019. The register matches documentation of the complaints in the folder. The complaint documentation was reviewed for two complaints. All complaints had noted investigation, timeframes, corrective actions when required, and resolutions were in place if required.</p> <p>There has been one complaint escalated by the complainant to the Health and Disability Commission in 2018. The complaint was investigated with a letter from the Health and Disability Commission confirming that no action was required in response to the complaint.</p> <p>Discussions with nine residents (five from the hospital including one requiring interim level of care and four from the rest home including one requiring respite care) and families confirmed that their issues are addressed, and they feel comfortable to bring up any concerns.</p>

<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>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Fifteen of fifteen incident/accident reports reviewed meet this requirement.</p> <p>Three relatives each with a family member in the hospital area interviewed, confirmed they are notified following a change of health status of their family member.</p> <p>There is an interpreter policy in place and contact details of interpreters are available. One resident speaks limited English; however, the family visit regularly and can interpret. Staff also use an interpreting app off the website particularly during activities to clarify, explain and ask for information.</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>Patrick Ferry House is an aged care facility that has 74 dual-purpose rest home and hospital (geriatric and medical) level beds. On the day of the audit there were 68 residents.</p> <p>The service is provided over two levels. On the day of audit, there were 33 residents across the 39 rooms on the ground floor (10 rest home and 23 hospital residents including two residents requiring interim care under the medical contract and one ACC funded resident). On level one (upstairs), there were 35 residents across the 35 beds (27 hospital including two residents admitted under an interim care contract; and eight rest home residents including one requiring respite level of care).</p> <p>A business plan is in place for 2018 and this was reviewed at the end of the year. A business plan for 2019 is documented. A mission, philosophy and objectives are documented for the service. The manager completes a monthly report for the general manager and other members of the upper management team, with a meeting held at least monthly to discuss the report and to review the day-to-day operations and progress against the business objectives.</p> <p>The hospital manager has previous health management experience, aged care experience for 20 years and has been in the role at this facility for seven months. The hospital manager has completed management training in the past through the district health board and is currently enrolled in a Diploma in Management through Careerforce.</p> <p>The hospital manager (registered nurse) is supported by a clinical manager who has been in the role for nine months, with extensive experience in palliative care nursing and management. There is a clinical coordinator who has been in the role for three years who also supports the clinical component of the service. The general manager provides overall support with at least once a week support on site.</p> <p>All managers have maintained a minimum of eight hours of professional development relating to managing an aged care service and to clinical governance with courses attended at the district health board.</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>A quality and risk management programme is in place. Interviews with the general manager, hospital manager, clinical manager, clinical coordinator, registered nurse, the contracted physiotherapist, the diversional therapist and activities coordinator, administrator, two maintenance staff, five healthcare assistants and cook, reflected their understanding of and involvement in the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data and complaints management. Data is being collected monthly, with documentation of analysis and discussion of trends with results communicated to staff. The internal audit schedule for 2018 has been implemented. Internal audits reviewed for 2018 confirmed that these had corrective actions in place and showed evidence of resolution of issues. There are a range of satisfaction surveys including a food satisfaction survey completed last in 2018 (just over 75% satisfaction overall with food services); a general resident and family satisfaction survey last completed in April 2018 with 87% satisfaction with care and services; employee satisfaction survey (80% satisfaction). Corrective action plans are documented with evidence of resolution of issues in a timely manner. The improvement required at the previous audit has been addressed.</p> <p>There are forums to discuss issues, review data and information and for staff to feed in suggestions for quality improvement. The following meetings are held with these minuted and circulated: monthly staff; two monthly management meetings; bi-monthly quality review meetings; monthly resident and family; monthly health and safety including infection control and two weekly clinical focused meetings for the clinical manager, clinical coordinator and registered nurses. There are also meetings that include those for the kitchen, activities staff and household staff.</p> <p>Falls prevention strategies are implemented for individual residents.</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (the general manager) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed through the health and safety meeting and as required.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse,</p>	FA	<p>There is an accidents and incidents reporting policy. The hospital manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff meetings and at clinical meetings relevant to the audience. A registered nurse conducts clinical follow-up of residents.</p> <p>A review of 15 incident forms sampled from January to February 2019 demonstrated that appropriate clinical follow-</p>

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>up and investigation occurred following incidents. All are reviewed and signed off by the clinical and hospital managers. The hospital manager then collates data with this tabled for discussion at relevant meetings.</p> <p>Discussions with the hospital manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Notification of any serious event (pressure injury above a grade three) has been forwarded to the appropriate authorities using a section 31 form.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (hospital manager, clinical manager, clinical coordinator, two registered nurses, two caregivers, kitchen manager/cook) documented a recruitment process which includes reference checking; criminal vetting, signed employment contracts and job descriptions; completed orientation programmes and annual performance appraisals.</p> <p>Registered nursing staff and other health practitioner practising certificates are maintained on file. All reviewed, evidenced current annual practicing certificates.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an annual education and training plan documented that exceeds eight hours annually with a review of training records confirming that these are well attended. The administrator scans attendance records into the electronic system with an electronic record kept of each staff members completed training.</p> <p>Seven registered nurses (including the hospital manager and the clinical coordinator) have completed interRAI training and have maintained their competency. The improvement required at the previous audit to completion of interRAI assessments in a timely manner has been addressed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	FA	<p>Policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. The hospital manager, clinical manager and clinical coordinator are on site Monday to Friday and all rotate on call after hours.</p> <p>An acuity system has been developed to ensure that staff are allocated on to an appropriate number of residents for whom they can provide care. The registered nurses are supported by sufficient numbers of caregivers.</p> <p>The ground floor (23 hospital, 10 rest home) and the upper floor (27 hospital, 8 rest home) has the same numbers of staff on the morning and afternoon shifts. In the morning, there is a registered nurse and five healthcare assistants</p>

and/or experienced service providers.		<p>on each floor including one short shift and four long shifts; in the afternoon there is one registered nurse and four healthcare assistants including one short shift on each floor. On nights, there are two healthcare assistants on each floor and a registered nurse who works across both floors. If an emergency bell is rung by a village resident, then a designated senior healthcare assistant attends. The registered nurse on nights does not attend to residents in the attached village. If further action is required, the registered nurse will arrange for the village resident to be transferred to Patrick Ferry House for closer monitoring or if required, arrange for a transfer to the district health board or to emergency services. The care staff interviewed advised that additional staff are provided when there is an increase in resident care needs.</p> <p>Activities staff are rostered on five days per week. There are separate domestic staff who are responsible for cleaning and laundry services.</p> <p>Interviews with staff, residents and family members identified that staffing is adequately provided to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All long-term residents have individual medication orders on the computerised system with photo identification and allergy status documented. The respite resident file reviewed had a paper-based file which was appropriately completed, signed and included any allergies and a photo</p> <p>The service uses a pre-packed pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use in either the upstairs or downstairs medication cupboard. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Administration sheets sampled, were appropriately signed. Twelve medication charts reviewed, identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. Two residents self-administer medicines and have current competency assessments around this. They have access to secure storage in their rooms. Staff check on each shift, that these residents have safely self-administered their medications.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>All food is prepared and cooked on-site. There is a qualified chef and a cook who cover the seven-day week. Kitchen staff have completed on-line food safety units. Staff have completed chemical safety training. There is a four-weekly seasonal menu that has been reviewed by a dietitian. The cook receives resident dietary profiles and is notified of any dietary changes and requirements. Dislikes are known and accommodated as confirmed in resident</p>

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		<p>interviews. Cultural and spiritual dietary requirements are met.</p> <p>Food is delivered in a bain marie to the upstairs kitchenette. Fridge and freezer temperatures were recorded daily. Food temperatures had been taken and recorded daily. All foods were date labelled and stored correctly. Residents and families complemented the meals.</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>Care plans sampled were paper based and goal orientated. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary. The service plans to move to a computer-based programme this year.</p> <p>There were five residents with nine wounds upstairs, including one resident with an unstageable pressure injury. There were ten residents with wounds downstairs. Assessments, management plans and documented reviews were in place for all wounds.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is contracted as needed.</p> <p>Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</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>There are four staff employed (two diversional therapists and two part-time activities coordinators) who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities for five days a week. Separate activities are planned for upstairs and downstairs, although residents can attend either activity as they prefer.</p> <p>Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance.</p> <p>Individual activities are provided in resident's rooms or wherever applicable.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly, and a copy of the programme is available in the lounge, on noticeboards and in each resident room. The group programme includes residents being involved within the community with social clubs, churches and schools.</p> <p>A member of the DT team interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop an activity plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</p>

		<p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>Patrick Ferry has its own van for transportation. Residents interviewed described weekly van outings, musical entertainment and attendance at a variety of community events.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled. Care plan reviews are signed as completed by the RN. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.</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>The service displays a current building warrant of fitness. Hot water temperatures are checked weekly. Medical equipment and electrical appliances have been tested, tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. Staff interviewed confirmed there is adequate equipment to carry out the cares, according to the resident needs, as identified in the care plans.</p> <p>There is a lift and stairs between floors.</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</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks.</p>

in the infection control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>Restraint is described by the restraint coordinator (registered nurse) as only used where it is clinically indicated, and other de-escalation strategies have been ineffective. There are nine restraints used in the service (seven bedrails and two lap belts) and three enablers (bedrails). A review of two files for one resident with a restraint (lap belt) and one with an enabler (bedrail) evidenced documentation of consent, monitoring of the device and resident at least two hourly and links to the care plan around use of the restraint or enabler. Documentation confirmed that any use of enabler is voluntary.</p> <p>Staff training is in place around management of any challenging behaviours with attendance records confirming that all care staff have attended training.</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.