

# Heritage Lifecare Limited - Hodgson House

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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:

<b>Legal entity:</b>	Heritage Lifecare Limited
<b>Premises audited:</b>	Hodgson House
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 30 September 2019    End date: 30 September 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	58

# 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

Hodgson House provides rest home, hospital and palliative care for a maximum of 65 residents. The service is owned and operated by Heritage Lifecare Limited (HLL) and managed by a care home manager who is a registered nurse with clinical and managerial experience in the delivery of aged care services. This person is supported by a clinical services manager.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the providers' contract with the district health board. (DHB). The DHB also requested additional information on specific areas of service delivery and staff training, which is responded to in the body of the report. The audit process included review of policy and procedures, review of resident and staff files, observations and interviews with residents, managers, families and staff. A clinical nurse specialist for palliative care, and a community occupational therapist were interviewed on site. There was no general practitioner (GP) available for interview.

Since the previous certification audit in January 2018 there has been an increase in the number of beds from 64 to 65 beds, and a new care home manager employed.

There were no improvements identified as a result of 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.

There are effective communication systems between staff, and residents and their families and with other health providers. The service adheres to the practices of open disclosure where necessary.

Review of complaint records and interviews with staff, residents and families demonstrated that complaints received since the previous audit have been managed effectively. There have been no complaints to the Office of the Health and Disability Commissioner (HDC), no police investigations, coroner's inquests or issues-based audits.

## 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.

The service is maintaining an effective quality and risk management system which includes regular monitoring of all service areas.

Adverse events are reliably reported by all levels of staff. There is evidence that people impacted by an adverse event are notified for example, general practitioners and families. Notification of serious events to regulatory bodies is occurring as required.

Human resources systems are in place and staff are recruited and managed effectively. Staff training in relevant subject areas is occurring regularly. All staff are supported and encouraged to attend ongoing performance development and achieve educational qualifications in health care.

There were adequate numbers of skilled and experienced staff on site to meet the needs of residents 24 hours a day seven days a week.

## 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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Access to the facility is appropriate and efficiently managed with relevant information provided to the resident/family.

The multidisciplinary team, including the registered nurses 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 reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

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

Nutritional meals, snacks and fluids are provided in line with recognised nutritional guidelines. The service has a current food control plan. Special dietary requirements are catered for. Residents verified satisfaction with 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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Hodgson House has a current building warrant of fitness. Improvements to the interior and exterior areas of the facility were noted on the day of the audit. Residents and families interviewed were satisfied with the environment.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint systems and practices meet the requirements of this standard. On the day of audit there were two residents using bed rails as restraints and one resident using bed rails as an enabler. Assessment, consent, approval and monitoring and review occurs in relation to the use of these interventions.

Staff training on the safe and minimal use of restraint and enablers is provided regularly.

## 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.

Staff demonstrated good principles and practice around infection control. Surveillance is guided by the surveillance policy and procedures. Aged care specific infection surveillance is undertaken, and results are 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
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service is maintaining a complaints register and effectively managing the complaints process, which was confirmed by interview with the care home manager and the records of the five complaints logged in 2019. The documents showed that each matter was acknowledged in writing and investigated immediately and managed effectively for resolution with the parties involved.</p> <p>Residents and family members interviewed said they understood the process for raising concerns and complaints and felt safe to do so. There was evidence of ongoing communication with the complainants and that where necessary, external advocacy had been offered.</p> <p>There were no open complaints with the Office of the Health and Disability Commission or the DHB on the day of audit.</p>
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment	FA	<p>The open disclosure policy clearly and accurately describes the principles of open disclosure and how to implement this when required.</p> <p>Family/whānau confirmed they are kept informed of the resident's status and are notified of adverse events. Contact with the family is documented if the resident has been involved in an incident/accident or there has been any change in the resident's condition. Details from doctors' visits are documented and communicated as</p>

conducive to effective communication.		<p>required.</p> <p>Staff know how to contact interpreter services 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>	FA	<p>Heritage Lifecare Ltd (HLL) strategic plan outlines the purpose, values, scope, and direction of the services provided. A facility specific document which responds to the organisation's strategic plan describes short and term objectives and links to associated operational plans. Documents reviewed and interview with the care home manager confirmed that service delivery performance and other operational matters are reported to head office monthly.</p> <p>The care home manager is a registered nurse (RN) with relevant qualifications. This person has been in the role for just over a year and has long term experience employed as an RN in aged care facilities. Responsibilities and accountabilities are defined in the individual employment agreement and job description. The care home manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through regular meetings with the DHB and other managers. The clinical services manager (CSM) is also an RN and has been employed at the facility for a long term. This person oversees all clinical matters, adverse events and quality monitoring.</p> <p>Hodgson House has agreements with the DHB for age related care (ARCC) in rest home, hospital medical and geriatric care, respite and palliative care, and the Ministry of Health (MoH) for Young People with Disabilities (YPD).</p> <p>On the day of audit 58 of the 65 beds were occupied. Twenty-five residents were receiving rest home level care and thirty three residents were receiving hospital care. There were four residents being cared for under the palliative care agreement. One hospital resident who was less than 65 years of age was receiving care under the MoH YPD agreement.</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>	FA	<p>The organisation (HLL), has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of complaints, the carrying out of internal audits across all areas of service delivery and monitoring of outcomes, surveying residents and relative satisfaction and the reporting and collation of adverse events such as accidents/incidents, pressure injuries, restraint interventions and infections.</p> <p>HLL uses the same system for each of its facilities to report their quality data, for example, the number of falls with or without injury, medicine errors, pressure injuries, restraint, urinary tract infections, bruising and skin tears, and staff incidents. This data is collated by the CSM who conducts a monthly analysis looking for trends and ensuring that actions are underway to remedy any unwanted trends. This is then submitted to HLL's national office who produce a monthly quality indicator report which shows how the facility compares with its other aged care facilities and whether they are over or under the benchmarked target in each category. Where gaps or</p>

<p>principles.</p>		<p>deficits in service delivery are identified corrective actions are developed and implemented to address any shortfalls. This was confirmed by review of documents, meeting minutes and interviews with staff and management.</p> <p>Information from quality monitoring is shared with staff at their regular monthly meetings and pictorial and written information was observed to be on display in staff areas. The staff interviewed confirmed that they are kept well informed and may also be involved in quality and risk management processes through internal audit activities, quality projects and acting as representatives for health and safety.</p> <p>Resident and family satisfaction surveys are completed annually. Results from the most recent 2019 survey revealed no major issues or areas of concern.</p> <p>Policies and procedures are controlled and managed nationally to ensure a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Policies are based on best practice and cover all aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process.</p> <p>The care home manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There had been no staff injuries requiring notification to Worksafe NZ.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms from 2019 revealed clear descriptions of the event and evidence of notifications to people impacted by the incidents. For example, family, the manager on call and/or the GP. All incidents were being reviewed and investigated by the CSM, to determine cause and effect and what if any type of actions were required to prevent recurrence. There was evidence that actions are monitored for implementation. Consequential actions are recorded in the resident's electronic progress notes. Adverse event data is collated, analysed and reported to staff as described in standard 1.2.3.</p> <p>The care home manager understood and adheres to the requirements for essential notification reporting, including for pressure injuries. The records showed eleven notifications of significant events as required by section 31 of the Health and Disability Services (safety) Act made to the Ministry of Health in 2019. These include three events of resident absconding, a power outage, physical confrontation between residents, four reports related to RN shortages, a stage three pressure injury which the resident was admitted with and call bell failures.</p> <p>There have been no infection outbreaks, police investigations, coroner's inquests, or issues-based audits.</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>Staffing policies and practices 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. The sample of seven 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 followed by an initial performance review.</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. Records reviewed demonstrated that 11 of the 42 caregivers have completed level 4 or higher of the National Certificate in Health and Wellbeing (or its equivalent). One carer has achieved level three, and one is at level one.</p> <p>Nine of the 10 RNs employed are maintaining annual competency requirements to undertake interRAI assessments.</p> <p>Ongoing training in the care of palliative residents is being provided to all RNs and caregivers assigned to these residents. This was sighted in personnel records sampled and a number of the caregivers interviewed said they had attended palliative care seminars. A palliative clinical nurse specialist who is a frequent visitor also confirmed they provide education and rated the knowledge and skills of staff as very good.</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>	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). Staff and managers reported that staffing levels are adjusted to reflect the acuity of residents. This is closely monitored by the CM and CSM especially when the number of hospital and palliative care residents increases. Observations and review of a four-week roster cycle showed that staff cover was adequate and that unplanned staff absences are covered by casual or agency staff. The service has been needing to back fill RN absences with bureau/agency staff and interviews were occurring on audit day to recruit more RNs. RN shortages have been reported via the section 31 process as described in standard 1.2.4. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>The clinical staff interviewed said that the number of floor staff allocated each shift was sufficient and that absences were more often than not replaced. This was supported by the residents and family members interviewed. There had also been gaps in the provision of cleaning staff but interviews were also taking place for these roles.</p> <p>A majority of staff members have current first aid certificates and at least one RN is on site 24 hours a day/seven</p>

		days a week (24/7) for emergency situations.
<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 staff observed administering medicines 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. Current medication administration competencies were sighted for all staff who administer medication.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription when medication is received from the pharmacy. All medications sighted were within current use by dates. The service has implemented an electronic medication management system. Staff have completed relevant training for the new system and other topics required for medicine management as per the training records.</p> <p>Interviewed staff demonstrated knowledge on controlled drugs management and storage requirements and are guided by the medication management policies and procedures when required.</p> <p>The required three-monthly medication review is consistently recorded on the medicine chart by the GP. On the reviewed medication charts, dates were recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were met. Monthly reviews/audits are completed from the electronic system utilised and reports were sighted. All allergies/sensitivities are documented for medication and food.</p> <p>There was one resident who was self-administering an inhaler at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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 are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a chef and one relief cook and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows a four weekly cycle pattern. The service has a contracted dietician who has audited the menu plans within the last two years.</p> <p>The chef is responsible for ordering, checking and storage of all food supplies. A bain-marie is used to deliver food to other dining areas. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the food safety plan. The chef and relief cook interviewed have undertaken a safe food handling qualification. Kitchen hands have also completed all relevant training and certificates are displayed.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile 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. Food allergies are documented and included in the</p>

		<p>care plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>The service has a current food control plan which expires 27 September 2020. This is displayed at the entrance to the facility.</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 care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident. The GP medical records verified that medical input is sought in a timely manner, that medical orders are followed, and care is implemented as required. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. Interviewed residents and families confirmed satisfaction with the care provided.</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 three staff; one diversional therapist holding the national certificate in diversional therapy, an assistant and an activities coordinator. The activities staff work collaboratively together to provide an interesting programme. The service regularly contributes to the Heritage Lifecare Limited (HLL) newsletter in regard to activities and special events.</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 residents' activity needs are evaluated six monthly and as part of the formal six monthly care plan review. Resident participation records are maintained.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Staff commented that the van used for activities cannot seat the number of residents who wish to go on outings in the community. This is currently being discussed at resident/family meetings. The residents/family meetings are valuable to evaluate and to improve the programme as needed. Residents interviewed confirmed they find the programme motivating and enjoyable.</p>
<p>Standard 1.3.8: Evaluation</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes by the care staff. If any change is noted, it is reported to the RNs. The RNs review and document in the progress notes when there is a need or changes in residents' conditions, and weekly as a minimum. One of the senior registered nurses discussed the</p>

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		<p>Hodgson House Lifecare schedules for the RN primary nurses to complete the interRAI assessments, lifestyle care plans and arrange the GP review dates in a timely manner. The interRAI assessments were up-to-date.</p> <p>Care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessments, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated for acute infections and wounds in the reviewed files. Unresolved problems were added to the long-term care plans after three weeks. Residents and families/whānau interviewed confirmed involvement in evaluation of progress and any resulting changes. Short term care plans were closed off when the short-term problems have been resolved.</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 26 January 2020) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. There have been no structural changes to the building. Improvements to the internal and external environment were observed, for example, replacement of flooring, painting, new furniture and general enhancements for the benefit of residents.</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 infection control coordinator reviews all reported infection, and these are documented. 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. The clinical indicator monthly summary was reviewed. 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 the previous month and year and this is reported to all staff and the infection control committee. Data is benchmarked externally with the other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate</p>	FA	<p>The restraint systems and practices meet the requirements of this standard. On the day of audit there were two residents using bed rails as restraints and one resident using bed rails as an enabler. Assessment, consent, approval and monitoring and review occurs in relation to the use of these interventions.</p>

that the use of restraint is actively minimised.		Staff training on restraint and enabler use is provided regularly.
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# 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
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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.

No data to display
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End of the report.