Marne Street Hospital Limited - Marne Street Hospital

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:	Marne Street Hospital Limited
Premises audited:	Marne Street Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 5 November 2019 End date: 6 November 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: 51

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

Marne Street Hospital provides hospital (geriatric and medical), rest home and residential disability (intellectual and physical) levels of care for up to 55 residents. There were 51 residents during the audit.

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

The facility manager is appropriately qualified and experienced and is supported by an experienced clinical manager, a quality coordinator registered nurses and long-standing caregivers.

The previous audit shortfall around progress notes has been addressed.

This audit identified no further areas for improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Residents and family are well informed, including of changes in resident's health. Management have an open-door policy. Complaints and concerns have been managed and a complaints register is maintained.

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 quality and risk management programme includes service philosophy, goals and a quality planner for 2019. Meetings are held to discuss quality and risk management processes. There is a health and safety management programme available to guide staff. Incidents and accidents are reported and investigated. There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme for 2019 is being implemented. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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.

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. All resident files reviewed evidenced that assessments, reassessments and care plans had been completed and evaluated in the required timeframes. The residents and relatives interviewed confirmed their input into care planning. Activity assessments and care plans are completed by the diversional therapist. The activity programme is age appropriate. The residents and relatives interviewed confirmed satisfaction with the activities programme and their ability to have it changed if desired. Individual activities are provided either within group settings or on a one-on-one basis.

There is an electronic medicine management system in place, medication processes are in line with current legislation. Food services are provided by an external catering company and resident interviews confirmed satisfaction with food services.

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 in place, and reactive and preventative maintenance occurs. The facility is spacious, with large and small lounge areas for residents and relatives to use. All communal areas are accessible to residents using mobility aids. External areas are accessible and well maintained.

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.

Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit, there were five residents using bedrails as restraints, four of these residents were using lap belts on wheelchair as restraints. There were a further six residents using bedrails as enablers and one of these residents was using a lap belt on a wheelchair as an enabler. Staff training has been provided around restraint minimisation and management of challenging behaviours.

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.

Marne Street Hospital has an infection control programme that complies with current best practice. The infection control programme is designed to link to the quality and risk management system. Infection data is collated, analysed and discussed at meetings. 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	17	0	0	0	0	0
Criteria	0	42	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	The service has a complaints policy that describes the management of the complaints process. Information about complaints is provided on admission to residents and their families/whānau. Feedback forms are available for residents and families/whānau in the foyer. All staff interviewed (four caregivers, two RNs, one GP, and one diversional therapist) were able to describe the process around reporting complaints. There is a complaint's register. Since the previous audit there have been eight complaints made. All complaints reviewed had a record of acknowledgement, written investigations, timeframes and where required, corrective actions were documented and implemented. Results and outcomes of the investigations are fed back to complainants. Discussions with residents/relatives confirmed that any issues are addressed, and they feel comfortable to bring up any concerns. Two previous complaints lodged with HDC (21 June 2016 and 15 May 2017) have been closed by the Health and Disability Commissioner in 2019. AS a result of the complaints the service has implemented corrective actions. There have been significant changes to policies, procedures and practices around wound care and pressure injury prevention. There has been more pressure relieving equipment purchased which is stored in a separate cupboard
Standard 1.1.9: Communication	FA	Accident/incidents, complaints procedures and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Ten incidents/accident forms reviewed included a section to

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		record NOK notification. All forms evidenced family were informed if they wished to be. Three hospital level relatives interviewed, confirmed that they are notified of any changes in their family member's health status. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. Three hospital and two YPD residents interviewed stated they are kept well informed by management.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Marne Street Hospital is certified to provide care for up to 55 residents at rest home, hospital (geriatric and medical) and residential disability (physical and intellectual) levels of care. Ten rooms are certified for dual-purpose with the remaining 45 rooms hospital only. On the day of the audit, there were 51 hospital-level residents including three residents on the young persons with a disability (YPD) contract, and one resident on a long-term support - chronic health contract (LTS-CHC). There were no rest home residents. The facility manager reported that they rarely admit a rest home level resident and would do so under special circumstances only. The facility is owned by three directors who regularly meet with the facility manager. An annual business plan has been developed for 2019 that includes a mission, vision, values and measurable goals. Staff acknowledged their understanding of the mission, vision and values during their induction to the service, evidenced via their signature. Business goals are regularly reviewed. An experienced facility manager is in charge of operations. She has previous experience in aged care and has been managing this facility for eight years. She receives support from an experienced clinical manager/registered nurse and a quality coordinator/enrolled nurse. The facility manager has completed at least eight hours of training related to management of an aged care facility, relevant to her role and responsibilities.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality	FA	There is a documented quality and risk management system. The content of the policies and procedures is detailed to allow effective implementation by staff. The services policies are reviewed annually. The quality and risk management system is designed to monitor contractual and standards compliance and includes schedules for training and audit requirements for the month and the managers and quality coordinator ensure completion of these requirements. Quality data is collated monthly and discussed with staff at regular meetings. The internal audit programme is being implemented and corrective action plans have been completed and signed off for internal audits that were not compliant. Quality initiatives and changes made as a result of satisfaction surveys, complaints and data collated include (but not limited to) trialling a new template for advanced care planning in hospital level care and Marne Street Hospital has been working closely with Hospice in developing this. Policy and procedures have been

improvement principles.		reviewed and updated and now include more information on wounds and pressure injury prevention. Comprehensive procedures have been developed and implemented. A pocket-sized resource has been developed for nurses and caregivers to prompt them of procedure for a variety of medical issues. The quality improvement register is maintained that keeps a running tally of quality initiatives and progress. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the annual resident/relative satisfaction survey completed in 2019 were similar to the 2018 responses. Improvements indicated in the relatives' survey included 11 relatives in 2018 and 14 in 2019 stated they were involved all or most of the time in care planning, and 10 relatives in 2018 and 13 relatives in 2019 stated they feel the service is quick to inform them of resident changes or adverse events. The resident survey 2019 showed overall satisfaction with services. Corrective actions were undertaken around the areas of lower satisfaction. There were improvements made around relatives' involvement in care planning, and prompt communication of adverse events and the location of staff. There was overall satisfaction with the activities programme. There is a health and safety and risk management programme in place including policies to guide practice. The facility manager is the health and safety officer (interviewed) and had completed the specific health and safety training requirements. Health and safety internal audits are completed. There is a meeting schedule including quality/RN meetings, department meetings, health and safety meeting and staff meetings. Meeting minutes reviewed showed a good flow of information. Toolbox meetings are held when issues arise with nurses and caregivers.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Staff, on interview, (two registered nurses, four caregivers, one activities person, and one kitchen staff) were aware of the process around accident and incident reporting. Ten accident/incident forms were reviewed for September and October 2019. Incident forms reviewed reflected a clinical assessment and follow-up by a registered nurse (RN) and identify opportunities to minimise the risks. Discussions with the managers confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is a separate file with section 31 notifications made including pressure injury notifications, falls with fractures, and resident behaviours.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies to support recruitment practices. Five staff files reviewed, including the clinical manager, two registered nurses and two caregivers evidenced employment contracts and completed orientation. A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme includes documented competencies and induction checklists. Appraisals have been completed annually. There is an annual education plan for 2019 which is being implemented according to schedule. Core competencies are completed, and a record of completion is maintained on staff files. The clinical manager (RN), quality coordinator (EN) and one RN (external) is interRAI trained. Due to the high registered nurse turnover to the local DHB. There are no other RNs trained in interRAI. The managers' reported low turnover amongst other staff. There are currently two caregivers with level 2 Careerforce qualifications, nine with level 3 and one with level 4. The diversional therapist has a level 4 qualification and there are two overseas trained registered nurses working as caregivers. All RNs and senior caregivers are first aid trained.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a safe staffing policy and procedure, which describes staffing, and this can be increased if resident acuity demands. The facility manager, clinical manager and quality coordinator work 40 hours per week from Monday to Friday. The facility manager is available on call for non-clinical matters, the clinical manager and senior registered nurses share on call for clinical advice. There are two RNs on duty in the mornings from 6.45 am to 3.15 pm, they are supported by 10 caregivers; 4x 7 am to 3.30 pm, 2x 7 am to 1.30 pm, and 4x 7 am to 1 pm. There are two RNs rostered on the afternoon shift from 2.30 pm to 11 pm, they are supported by six caregivers; 3x 3 pm to 11 pm, 1x 3 pm to 10 pm, and 2x 4.45 pm to 10 pm. There is one RN and two caregivers during the nightshift. Staff sickness and vacant shifts are covered. Staff, residents and relatives interviewed confirmed that staff are replaced and feel staffing is adequate.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable,	FA	All relevant initial information was recorded within required timeframes into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Archived records are secure in a separate locked storage facility located on the premises. Care plans and notes are legible. The progress notes evidence the person completing the entry including date and time including the signature and

accurately recorded, current, confidential, and accessible when required.		designation. The previous finding has been addressed. Individual resident files demonstrated service integration including records from allied health professionals and specialists involved in the care of the resident. Information in the electronic medication management system and interRAI data are password protected.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	Medication policies align with accepted guidelines. RNs are responsible for the administration of medications and all have completed an annual medication competency. The service uses an electronic medication management system and have recently moved to robotic rolls. Registered nurses complete a medication reconciliation on delivery. There were no expired medications in the trolley or medication cupboards. Ten medication charts reviewed identified photo identification and allergy status. Also, the GP had seen and reviewed the resident three monthly and the medication charts were signed. The signing sheets in the electronic system demonstrated that medications had been dated and administered as prescribed on the medication chart for all regular and 'as required' medications. Warfarin doses are authorised through the electronic medication system. Two residents self-administering their inhalers with a competency assessment has been completed with GP authorisation and are reviewed three-monthly. There is evidence of the self-administering being monitored through the electronic medication system. All RNs have a syringe driver competency. Standing orders were not in use. Two RNs were observed administrating medications safely and correctly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	An external food service provides all meals, including morning and afternoon tea. The meals are plated and transported to the facility in hot boxes just prior to service. Temperature testing occurs and meets the requirements of the Food Control Plan (FCP). A small stock is kept in the kitchen to accommodate last minute changes in food service. There is a four-weekly seasonal menu, which was approved by a dietitian in September 2019. Special diets are catered for including (but not limited to); diabetic, high protein, vegetarian, pureed, soft, and gluten free. The facility has a food control plan in place which is valid until February 2020. There is an app that records all the fridge, freezer and chiller temperatures that are taken and recorded daily. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules were maintained. Staff who work in the kitchen have completed a food safety course. The residents' nutritional profiles are kept in a folder in the kitchen with a board for food preferences with food allergies, likes and dislikes listed. This information is also provided to the contractor. The folder includes all dietary information and is updated when a new resident enters the service. Information includes dietary changes

		and/or weight loss. The breakfast menu is prepared and served by the staff. Meals are plated and served at the main kitchen and the kitchenette next to the second dining room/lounge. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. There is specialised crockery such as lip plates and mugs and utensils to promote resident independence with meals. Residents and family members interviewed were very satisfied with the food services and reported that alternative food choices were offered for dislikes.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required a GP. There is documented evidence where care plans have been updated to reflect the changes in resident needs/supports. Short-term care plans are developed for infections, wounds and pressure injuries, weight loss and challenging behaviour. On the day of the audit there were 13 wounds across the facility including skin tears, surgical wounds, pilonidal sinus and nephrostomy sites. There were three residents with stage 1 pressure injuries, one resident with a stage 2 and one resident with a non-facility acquired stage 4 pressure injury. All wounds included a wound assessment and treatment plan and regular evaluations have been completed, photographs of chronic wounds routinely occurred on the same week each month. The RNs have access to specialist nursing wound care management advice if required. The dietitian and wound care specialist have had input into the stage 4 pressure injury. Adequate dressing supplies were sighted in the treatment room. Since the previous audit the wound policy and assessment forms have been reviewed to be more user friendly and to include relevant information required including specialists available. Incident forms now include the Waterlow assessment scoring pressure injury and grade and when to discuss with the clinical manager. Short-term wound assessment plans include whether the wound/pressure injury was present on admission, the frequency of monitoring required and an assessment of the wound. The wound logs in the wound care file contained information on when the wound commenced and resolved, and monitoring required. The registered nurses interviewed were fluent on the specialist input available from the DHB and Hospice and who is responsible for referrals to services. Continence products are available and resident files included a continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Monitoring forms in place included (but are not limited to); monthly weight, blood pressure and pulse, food and fluid charts, change of position and behaviour. Residents and relatives confirmed their expectations are met and they are kept informed of any changes to health.

Standard 1.3.7: Planned Activities 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.	FA	An experienced diversional therapist (DT) provides planned activities Monday to Friday. There is a second DT and an activities coordinator working on completing her training. The team all have their special strengths that they bring to the service. There is a weekend afternoon role when they focus on one-on-one time with residents. The programme is further enhanced by six volunteers who are involved with residents. The activities programme calendar is completed fortnightly and is displayed in the communal areas. There is a comprehensive assessment and individual activity plan developed for each resident and these are reviewed at the same time as the care plan in all resident files reviewed. Residents/family have the opportunity to provide feedback on the activity programme through resident meetings, six-weekly surveys and multidisciplinary care reviews. Residents at Marne Street Hospital do not go on planned facility outings as there is no van. Given this the activities and team, work to ensure links with the community are arranged as required. The DT stated that there are numerous schools and other community groups that visit the facility along with regular entertainers. There are four younger people, special consideration is given when planning the activities programme for them. An interview with one of these residents confirmed that the programme also meets the individual needs of the younger residents. The YPD resident's file had a range of interventions documented to allow them to participate in a range of cultural, educational and leisure activities consistent with their needs and preferences. The residents and relatives interviewed confirmed satisfaction with the activities programme and their ability to have it changed if desired.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations described the resident's progress against the resident's (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The GP reviews residents at least three-monthly or when there is a change in health status. The relatives interviewed confirmed they are invited to attend the GP visits and multidisciplinary care plan reviews.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	The building warrant of fitness expires on 7 October 2020. A preventative maintenance plan is implemented. There is a comprehensive check system of the building and equipment to be carried out by the maintenance person. Electrical appliances and medical equipment are tested and tagged by contracted service providers. Hot water temperatures are monitored monthly and required remedies (if any) are addressed in timely manner. There are large open plan lounge/dining areas and smaller quiet lounge areas for residents and relatives to use, all communal areas are spacious and accessible to residents using mobility aids. The external areas are well maintained, and residents can access gardens and indoor areas with ease. There have been specialised locks placed on to fire exits to prevent wandering residents exiting the building without staff awareness, this was put in

for their purpose.		place following an incident. There is a dedicated storage area for specialised equipment such as pressure relieving equipment and matrasses with a log of who has what equipment and photos of the correct procedure for setting up equipment. There is a dedicated smoking area and residents are monitored when they smoke.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The quality coordinator (EN) is the infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Infection surveillance is an integral part of the infection control programme and is linked to the quality management programme. Surveillance of all infections is entered onto a monthly infection summary, graphed and evaluated monthly and annually. Reports of antibiotic usage is available on the electronic medicine management system. The service is working with the pharmacy and GP around reducing the incidence of urinary tract infections. Results of surveillance are acted upon in a timely manner. Outcomes and actions of IC surveillance programme is discussed at all meetings. The information obtained through infection surveillance and internal audits determine infection control activities, resources and education needs within the facility. There have been no outbreaks since 2015.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The policies and procedures include definitions, processes and use of restraints and enablers. On the day of audit, there were five residents using bedrails and four residents using lap belts as a restraint on specialised wheelchairs. Appropriate assessments monitoring, and consents were in place and reviewed three monthly with the GP. There were six residents using bedrails and one resident using a lap belt as an enabler. Staff training has been provided around restraint minimisation and management of challenging behaviours (June 2019) and during orientation. Restraint audits are completed six monthly.

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, these 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.