Many Hands Limited - Cornwall Rest Home

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 Central Region's Technical Advisory Services 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:	Many Hands Limited
Premises audited:	Cornwall Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 May 2021 End date: 11 May 2021

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: 27

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

Cornwall Rest Home is privately owned. The service is certified to provide rest home care for up to 27 residents. There were 27 residents in the facility on the day of audit.

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

The owner/manager (non-clinical) has been in his role for three years. They are supported by a supervising registered nurse who has been in her role for eight months, and by experienced staff.

Cornwall Rest Home has a quality and risk management system in place. Residents and family interviewed were complimentary of the care and support provided.

The service has addressed the previous certification shortfalls around: neurological monitoring post falls; planned activities; care evaluation; medication management; storage of chemicals; and emergency water supplies.

This audit has identified no areas requiring 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.

The service has a culture of open disclosure. Family are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code), and a complaints register is maintained.

Residents and family interviewed verified ongoing involvement with the community.

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 business plan with goals for the service that has been regularly reviewed. Cornwall Rest Home has an implemented, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and patient surveys. Incidents are appropriately managed.

There are human resource policies including recruitment, job descriptions, selection, orientation and staff training and development.

The service orientation and annual in service training programme provide staff with relevant information for safe work practices. Staff are supported to undertake external training. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care. The service has a documented rationale for determining staffing levels and residents and relatives reported staffing levels are sufficient to meet resident needs.

Continuum of service delivery

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

The supervising registered nurse assesses residents on admission. The initial care plan guides care and service provision during the first three weeks after the resident's admission to the facility.

The interRAI assessments are used to identify residents' needs and these are completed within the required timeframes. The general practitioner completes a medical assessment on the resident's admission and reviews occur thereafter on a regular basis.

Long-term care plans are developed and implemented within the required timeframes; they are individualised and based on an integrated range of clinical information. Residents' needs, goals and outcomes are identified. All residents' files reviewed demonstrated evaluations were completed six-monthly or when the resident's condition changes. Residents and their relatives are involved in the care planning process and notified regarding any changes in a resident's health status.

Short-term care plans are in place to manage short-term issues or problems as they arise. Handovers between shifts guide continuity of care and teamwork is encouraged.

An electronic medication management system is in place. Medication management is in line with the legislation and contractual requirements. Medications are administered by the registered nurse and health care assistants who have completed current medication competency requirements.

The activity programme is managed by an activity coordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community, including through the use of a facility van for outings. The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control plan. Kitchen staff have food safety qualifications.

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.

The building has a current warrant of fitness. There are sufficient bathroom facilities to meet the needs of residents. Internal and external areas are safe and easily accessible for residents and family members.

The building, plant and equipment comply with legislation. There is a preventative maintenance schedule in place. Chemicals are stored safely throughout the facility and there is appropriate protective equipment and clothing for staff. There are policies in place for emergency management.

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.

Cornwall Rest Home has restraint minimisation and safe practice policies and procedures in place. There is a documented definition of restraint and enablers that aligns with the Standards. There was one resident requiring the use of a restraint, and one resident using an enabler at the time of audit. Staff receive training around restraint minimisation and 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.

The infection control programme is appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed and trended. Monthly surveillance data is reported to staff. There has been one outbreak 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	18	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	The service has a complaints policy that describes the management of complaints process in line with the Code, including the timeframes for responding to a complaint. Information about complaints is provided on admission. Interviews with residents and relatives confirmed an understanding of the complaints process. An up-to-date complaints register is in place and includes: the date the complaint is received; the category of complaint and a summary of the complaint; acknowledgement of the complaint in writing, the date and record of any meeting/discussion; and the date the complaint was closed/resolved. Evidence relating to each lodged complaint is held in the complaints folder with the register. There is evidence of the complaints being discussed in quality/management and staff meetings with additional education provided as needed in response to the complaint motives. There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit.
Standard 1.1.9: Communication Service providers communicate	FA	Information is provided at entry to residents and family/whānau. A relative and residents interviewed stated that they were welcomed on entry and were given explanation about the services and procedures. There is a policy to guide staff on the process around open disclosure. Relatives and residents interviewed complimented the service regarding the open communication and ease of access to the owner/manager and the

effectively with consumers and provide an environment conducive to effective communication.		supervising RN, and confirmed that they are notified promptly of any incidents/accidents. Residents/relatives also have opportunities to feedback on service delivery through annual surveys and resident meetings. Review of meeting minutes and interviews with five residents demonstrated that resident meetings encourage open discussion around the services provided. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required through the district health board (DHB).
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Cornwall Rest Home has a documented strategic plan and mission, vision and values statement which reflect a person/family-centred approach to all residents. The service has a business plan, which is reviewed annually and identifies quality goals. Cornwall Rest Home is a 27-bed rest home. On the day of the audit, there were 27 rest home residents: 25 under the age-related residential care (ARRC) agreement; and 2 residents were under the DHB long-term support chronic health care (LTS-CHC) contract. There were no residents under DHB short-term respite contracts on the days of audit. The facility is managed by an owner/manager who is involved in the day to day running of the service and who is supported by an experienced registered nurse (RN). The owner/manager is a an RN; however, is currently not in clinical practice. The manager has completed at least eight hours of professional development related to managing a rest home, and the supervising RN has attended study days through the DHB.
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	Cornwall Rest Home has an quality and risk programme, incorporating a new information technology (IT) programme that allows for risk management and monitoring policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. New and revised policies are presented to staff at staff meetings and policy updates are also provided as part of relevant in-service education. Staff interviews confirmed that they are made aware of new and updated policies at meetings and also through the electronic log on system. Monthly quality meeting minutes and monthly staff meeting minutes (sighted), evidenced there is discussion around quality data including: complaints; compliments; health and safety; accident/incident; infection control; internal audits and survey results. The staff interviewed were aware of quality data results, trends and corrective actions. Service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators such as: falls; infections; medication errors; weight loss; wounds; and implementation of the internal audit programme. There

improvement principles.		is evidence that the annual internal audit programme is implemented as scheduled. Reports show evidence that quality improvement data is being collected and collated with the identification of trends and analysis of data. Where required, corrective action plans from quality activities are developed, implemented, evaluated and closed out. Staff interviews confirmed that they are advised of any subsequent changes to procedures and practice through meetings and meeting minutes. The owner/manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigations. Resident surveys are conducted annually. The resident/relative survey was last conducted late in 2020, results showed a 75% approval rate with overall satisfaction, especially around the friendliness of staff. A corrective action regarding food services is completed, and food waste is now monitored to ensure meals served meet the likes of residents, meals that are not enjoyed are reviewed and the menu is amended. There was evidence that those continuous improvements had resulted in a gain of satisfaction.
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	There is an incident reporting policy that includes definitions and outlines responsibilities. All completed incidents/accidents forms reviewed documented timely RN review and follow-up. Neurological observation forms were documented and completed for all falls with as per post-fall evaluation policy. The electronic event forms have a section to indicate if families have been informed (or not) of an incident/accident, and these were fully completed, including documentation of the reason if the notification did not occur. Opportunities to minimise future risks (where possible) were identified and implemented. Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the supervising RN. Interviews with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification reported since the last audit. Accident/incidents are graphed, trends analysed and specific learnings and results from accidents/incidents inform quality improvement processes that are shared at monthly staff meetings. Falls management strategies include assessments after falls and individualised strategies, with all falls being followed up with neurological observations. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.
Standard 1.2.7: Human Resource	FA	There are human resources policies to support recruitment practices, and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job

Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		descriptions, with accountabilities, responsibilities and reporting lines clearly identified. The register of the RNs' practising certificate and allied health professionals' is current. All files contained relevant employment documentation including current performance appraisals (two new staff were not yet due) and completed orientations. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; identification verification; a position specific job description; and a signed employment agreement. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home care. Staff interviewed believed new staff are adequately orientated to the service on employment. There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. The service has also completed a wide range of additional training such as customer care and medication updates as examples. These have been in response to issues raised and incidents. Staff are supported with external education: three health care assistants (HCAs) have achieved level four Careerforce and one level three and one level two, new staff are yet to begin training. The supervising RN has completed interRAI training. The owner/manager and supervising RN can attend external training including sessions provided by the local DHB. A competency programme is in place that includes annual medication competency for staff administering medications. There is a minimum of one staff member with a current first aid certificate on every shift.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing policy provides guidance to ensure staffing levels within the facility are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract. Rosters are available to staff in advance and staffing levels are reviewed to accommodate anticipated workloads, identified numbers of residents, and ensure that there is the appropriate skill mix of staff available. Additional staff are rostered on duty or an additional short shift is provided when required (eg, palliative care), Staffing rosters were sighted and there was an adequate number of staff on duty to meet the resident's needs, on different shifts. The owner/manager and supervising RN are on site during the day Monday to Friday and on-call 24/7. There are 2 HCA on the morning shift from 7am to 3pm and 1 HCA from 7am to 12pm. The afternoon shift has 1 HCA from 3pm to 11pm, 1 HCA from 3pm to 10pm and there is 1 HCA on the night shift. Residents and a relative stated there were adequate staff on duty. Staff stated they feel supported by the owner/manager and supervising RN who respond quickly to after-hour calls. Staff confirmed that they have sufficient time to complete their scheduled tasks and resident cares.

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	A current medication management policy identifies all aspects of medicine management in line with the medicines care guide for residential aged care. A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices are in line with legislation, protocols and guidelines. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities were documented on the electronic medication chart. The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing orders used at the facility. Review of the medication fridge evidenced that the service does not store or hold vaccines and interview with the RN confirmed this. The medication refrigerator temperatures are monitored weekly and medication room temperatures are monitored daily. Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly stocktakes of medications are conducted in line with policy and legislation. The staff observed administering medication demonstrated knowledge of medicine administration policies and procedures, and at interview they demonstrated clear understanding of their roles and responsibilities related to each stage of medication management. The RN oversees the use of all pro re nata (PRN) medicines, and documentation made regarding effectiveness on the electronic medication record and in the progress notes was sighted. Current medication competencies were evident in staff files. There were no residents self-administering medication at the time of the audit. The previous corrective action relating to checking in of medications by two staff is now closed.
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	All meals at Cornwall Rest Home are prepared and cooked on site. There is a four-weekly rotating menu, which has been reviewed by a dietitian. The food control plan was verified and is due to expire on 31 July 2021. All food is stored in accordance with the required standards. A regular cleaning schedule is implemented. Meals are prepared in the kitchen adjacent to the rest home dining room and served directly to residents. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the RN. Interview with the supervising RN and the cook confirmed high protein drinks are supplied for those residents identified as being at risk of weight loss. Weights are monitored monthly or more frequently if required and as directed. Fridge and freezer temperatures are monitored and recorded daily. Observation at lunchtime confirmed those residents requiring extra support to eat and drink are assisted by staff appropriately. Residents and family

		interviewed confirmed satisfaction with the food service.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Long-term care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. Care planning includes specific interventions for long-term and acute problems. Interventions are reviewed within required timeframes and updated if there are changes in the health status of a resident. The GP documentation and records reviewed were current. Interviews with residents and family confirmed that care and treatment met residents' needs. There was evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken and recorded where this was required. Where wounds required additional specialist input, this was initiated. Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Family communication is recorded in the residents' files. The nursing progress notes are recorded and maintained. Monthly observations such as weight and blood pressure were completed and are up to date. Residents and family interviewed expressed satisfaction with the care provided.
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	The residents' activities programme is implemented by the activities coordinator who has started diversional therapy training through Careerforce. Activities for the residents are provided five days a week, Monday to Friday, 10am to 4pm. The activities programme is displayed on the residents' noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural and community events. Regular van outings into the community are arranged. The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the RN. Information on residents' interests, family and previous occupations is gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed every six months at the same time the care plans are reviewed and are part of the formal six-monthly multidisciplinary review process. The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities. The previous corrective action relating to activities assessments is now closed.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. Any change noted is reported to the RN. Long-term care plans are evaluated every six months in conjunction with the interRAI re-assessments or as the residents needs change. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. Residents and family interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified, this is documented in the individual resident files reviewed. Short-term care plans are developed for acute problems when needed and record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved. The previous corrective action relating to formal long-term care plans evaluations is now closed.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current warrant of fitness due to expire on 11 November 2021. There has been no addition/alteration to the facility since the last certification audit.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The previous finding concerning safe storage of cleaning chemicals in the kitchen and cleaning cupboards has been addressed with padlocks installed so that products are only accessible by staff.

Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is a sufficient amount of fresh water to support residents and staff for the required seven days of an emergency (4000 litres). The previous finding from the certification audit is closed out.
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 Cornwall Rest Home surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed. The RN is the infection control nurse (ICN) and is responsible for the surveillance programme. Infection control surveillance occurs monthly with analysis of data and reporting at staff and quality meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infections. In interview staff reported they are made aware of infections through: handovers; progress notes; short-term care plans and verbal feedback from the RN and manager. New infections and any required management plan are part of the handover, to ensure early intervention occurs. Families are updated by phone, email or text if required. Short-term care plans are developed to guide care and evaluate treatment for all residents who have an infection. There has been one outbreak (Norovirus) since the last audit. Review of documentation evidenced this was managed and reported as required. Covid-19 information is available to all visitors to the facility. Ministry of health information was available on site. Infection prevention and control resources were available should a resident infection or outbreak occur.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of	FA	Cornwall Rest Home has policies and procedures which include a definition of restraint and enabler that are congruent with the definition in the Health and Disability Services Standards 8134.0. The restraint coordinator is the owner/manager and a signed position description was sighted. Restraint is only used as a last resort once all alternative strategies are considered. Enablers are voluntary, and the least restrictive option is in use to maintain resident independence and safety. The restraint register is maintained and current.

restraint is actively minimised.		There was one resident requiring restraint and one resident using an enabler at the time of the audit. The restraint coordinator confirmed the use of enablers/restraint is discussed at the monthly combined quality/health and safety/infection control meetings, and staff meetings. Restraint use is included in orientation for clinical staff. Challenging behaviours and restraint minimisation and safe practice education is provided.

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.