# Liberty 2000 Limited

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Liberty 2000 Limited

**Premises audited:** Kintala Lodge Rest Home

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

**Dates of audit:** Start date: 30 April 2015 End date: 30 April 2015

**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:** 18

# 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 |
|  | 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

Kintala Lodge Rest Home provides secure dementia rest home level care for up to 30 residents. On the day of audit, there were 18 residents.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board. The number of criteria reviewed has been increased in response to the district health board’s portfolio manager’s queries as part of follow up to complaints made since the previous audit. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with family/whānau, management staff and a general practitioner. Resident interviews were not relevant owing to all residents having varying degrees of dementia.

Feedback from residents and family/whānau members was very positive about the care and services provided.

No areas for improvement were found during the 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. |

Staff communicate effectively with residents and provide an environment conducive to good communication. There are processes in place to access interpreting services when this is required.

There were no concerns or observations of breaches in relation to residents’ privacy, abuse or neglect.

The service has a documented complaints management system which was implemented. There were no outstanding complaints at the time of audit.

## 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. |

Kintala Lodge Rest Home (Kintala) has their purpose, values, scope, direction and goals documented. Business processes related to planning are identified and the quality and risk system covers all aspects of service delivery. The processes in place allow residents need to be identified and met in a coordinated and safe manner.

Corrective action planning is implemented to manage any areas of concern or deficits identified. Evaluation of corrective actions is clearly shown prior to being signed off by the general manager/owner. The quality management system included an internal audit process, complaints management, family/whānau satisfaction surveys and collection of data related to incident/accidents, restraint and infection control. Quality and risk management activities and results are shared among staff and family/whānau, as appropriate. The reporting process includes bi-monthly written reports to the owner/director.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

## 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 processes for assessment, planning, provision, evaluation and review of care are provided within time frames that safely meet the needs of the resident and the funder’s contractual requirements. The care and services provided are appropriate to residents living in a specialist secure dementia care facility. The care plans identify the resident’s needs and have clearly documented interventions to address any assessed needs. There are specific strategies and plans for the management of challenging behaviours, falls reduction programmes and weight management programmes.

The care is evaluated at least six monthly. When there are changes in the resident’s needs the care plans are updated, or short term care plans are used to address the temporary needs. The service is coordinated in a manner that promotes continuity in service delivery and a team approach to care delivery.

The activities are planned and provided to develop and maintain skills and interests that are meaningful to the resident. There are activity plans and diversional activities to manage any challenging behaviours over a 24 hour period.

There are processes in place for safe medicine management. Staff responsible for medicine management are assessed as competent to perform the function for each stage they manage.

The food, fluid and nutrition services are suitable for the older person living in long term care. The menu has been reviewed by a dietitian. Any special nutritional needs are met by the service. There are appropriate management plans for when unexpected weight loss occurs.

## 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. |

There is a current building warrant of fitness and documentation to identify how all requirements are being met.

## 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. |

Policies and procedures in place reflect current good practice and meet legislative and Health and Disability Services Standards requirements. Policy identifies enablers are voluntary and cannot be used at Kintala owing to resident’s not being able to make meaningful decisions. Staff undertake annual restraint minimisation education so they have a full understanding of what is required to manage restraint safely. The service has one bedside rail and one chair safety seat in use.

## 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. |

There is a monthly review of infections. The infection data is collated, reviewed and analysed, with interventions implemented to reduce and prevent infections. The infection data and recommendations are reported to staff and management in a timely manner.

## 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 | 20 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 44 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | Policy and procedures identify that the organisation is committed to an effective and fair complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents, including complaints. The complaints process is discussed with family/whānau during the admission process and is included in new staff orientation and in the ongoing education programme. Family/whānau confirmed that the management’s open door policy makes it easy to discuss concerns at any time. The complaints received since the previous audit has been managed within policy timeframes and are resolved. There are no outstanding complaints at the time of audit. This was confirmed in the complaints register sighted. All issues identified by two complaints made to the Waikato District Health Board in 2014 and one complaint made to the Health and Disability Commissioner in 2013, have corrective actions shown and the service can demonstrate that the practices put in place are embedded into everyday service delivery.Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur. Complaints are a standing agenda item for staff meetings, as confirmed by meeting minutes sighted. They are also reported to the owner/director verbally and during bi-monthly formal management meetings as confirmed in documentation sighted.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | At the request of the DHB, the standards for privacy and freedom from abuse and neglect were reviewed at this audit. There were three double rooms in use at the time of audit. Each of these rooms have privacy curtains and the resident’s physical and visual privacy is maintained. When private discussion is required these do not occur in the resident’s room, they take place in the nurses’ station. There are private rooms where family can have personal time and privacy with their relatives. The nurses’ office is private and secure from the resident areas, where private conversations and handover occur. The family/whanau and GP have no concerns regarding abuse or neglect. The staff interviewed demonstrated knowledge of what to do if they suspect any abuse or neglect.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service promotes an environment that optimises communication through the use of interpreter services as required and staff education related to appropriate communication methods. The service has not required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. The family member interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented on family contact sheets, emails, newsletters and in the residents' progress notes sighted. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Strategic planning is identified in the 2014-2015 business plan. It covers all aspects of service delivery. The vision and mission statements of the organisation are documented and reviewed annually as part of the business planning process. Risk management is included in the business planning process. The general manager, who works full time at the facility, has co-owned and operated the facility for over 14 years. Bi-monthly formal meetings are held with the director (co-owner) and all areas of service provision are discussed. The general manager is supported by a registered nurse with a current practising certificate who has many years’ experience in care of the aged. Both members of the management team attend education appropriate to the role they undertake. Job descriptions identify management members’ experience, education, authority, accountability and responsibility for the provision of services. Interviews with family/whānau confirmed their relatives’ needs are met by the service.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has a quality and risk management system which is understood and implemented by service providers. This includes the development and update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, restraint, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. All reporting is linked to management processes via a bi-monthly management report which is recorded and discussed at meetings. This information is used to inform ongoing planning of services to ensure residents’ needs are met. Quality improvement data is benchmarked by an offsite organisation against other like facilities and compared to previously collected data on-site. This is an improvement that has been put in place since the previous audit. Staff and family/whānau interviewed confirmed any concerns they have were addressed by management and verbal examples of quality improvements were given.Actual and potential risks are identified and documented in the hazard register. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.  |
| 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 | Policy identifies that the organisation requires all incidents, accident and adverse events to be reported immediately. The service providers fully understood their obligations in relation to essential notification reporting and know which regulatory bodies must be notified. Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. Incident and accident forms sighted were well documented and any corrective actions to be taken are shown on the forms used by the service. Any documented corrective actions are evaluated prior to sign off by the general manager. The incidents and accident forms reviewed corresponded with information sighted in the files reviewed.Family/whānau interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives.  |
| 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 | Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Newly appointed staff are police vetted upon employment, referees are checked and job descriptions describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles as confirmed in staff files reviewed. Staff meeting minutes identify that the issue of burnout, stress and tiredness has been discussed and management alerted staff that they are able to assist them with professional counselling if required. Staff are also encouraged to discuss any problems with the registered nurse or management. It was verbalised where the offer had been accepted and resolved. Staff undertake training and education related to their appointed roles. Staff education onsite includes guest speakers, off-site seminars and training days which cover topics to ensure all aspects of service provision are met. This was confirmed in the education records sighted for 2014-2015. Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted. All caregivers have either completed or are working towards completion of accepted qualification related specifically to dementia care. (The registered nurse is an aged care education assessor).Family/whānau members interviewed, along with the 2015 satisfaction survey results, identified that residents’ needs are met by the service. No negative comments were voiced during interviews on the days of audit. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy identifies staffing levels and skill mix is maintained to meet residents’ needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe and quality care. The service operates on a two week rotating roster where each staff member is allocated set shifts. The service meets registered nurse hours, in accordance with the indicators for Safe Aged Care and Dementia Care for Consumers. The nurse manager reported that additional staff would be rostered to meet increased residents’ needs and this was confirmed by staff interviewed. A review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents’ needs. There is a registered nurse and medical staff on call at all times. Family/whānau interviewed stated they feel all their relatives’ needs are met in a timely manner. There is always a staff member on duty that holds a current first aid certificates. The diversional therapist works Monday to Friday and dedicated kitchen and cleaning/laundry staff seven days a week.  |
| 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 | Medicines are supplied by the pharmacy in a pre-packed administration system. The RN reviews the medications delivered for accuracy against the medicine charts. The GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists. Safe medication administration was observed. The medicines and medicine trolley were securely stored during the audit. Medications that required refrigeration were stored appropriately within medicine storage guidelines. There were no controlled drugs. All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. The annual medication review conducted as part of the internal audit process confirms compliance with standards and best practice guidelines. Standing orders are not used at the service, with all medications individually prescribed for each resident. Medication competencies were sighted for all staff that assisted with medicine management. Self-administration of medications is not appropriate at this dementia care service.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The Ministry inspection in 2013 identified areas for improvement at criteria 1.3.13.1 and 1.3.13.2 to ensure the menu is reviewed two yearly and where weight loss occurs appropriate referrals occur. These issues are now addressed. The service has a four week rotational menu with summer and winter variations. The menu has been reviewed by a dietitian within the past two years as suitable for the residents.Residents are routinely weighed at least monthly. Residents with unexpected weight loss have their weights monitored weekly. Appropriate interventions were put in place for residents with unexpected weight loss. Residents with additional or modified nutritional needs or specific diets have these needs met. There is a weight maintenance programme that includes nutritional assessments and specific feeding evaluation for dementia care questionnaires and nutritional supplements for residents. There are nutritious snacks available 24 hours a day. The family/whanau satisfaction with meals, fluids and the nutritional services is evidenced through satisfaction surveys and interviews at the time of audit. The residents are observed to be eating a well presented, nutritious meal at lunch. All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. The service has an annual external inspection of the kitchen against the food hygiene regulations; this expires in June 2015.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The inspection conducted by the Ministry of Health (Ministry) in March 2013 identified that there was an area for improvement at criterion 1.3.4.2. The Ministry identified that there was no weight management programme, or rationale to determine actions should a resident have significant weight loss. The service has implemented and embedded a weight management programme into daily service delivery. The weight management programme includes referral to the GP, additional nutritional supplements, monitoring of food and fluid intake and at least weekly weighs. The resident reviewed using tracer methodology has gained weight since admission. There are appropriate assessments of the resident’s needs with the care requirements recorded in the care plan. The service had commenced the use of the interRAI assessment tool, with further training for two newly employed registered nurses (RN) planned for 2015. Four of the five files reviewed had an interRAI assessment conducted, with the other files evidencing the services assessment tools and assessment processes. The assessments and care plans include the physical, psycho-social, spiritual and cultural needs of the residents. In addition to the interRAI assessment there are specific assessments for falls, nutrition, behaviour, pressure area risk, mobility and pain assessments sighted in the files reviewed. The GP reported satisfaction with the management of falls and any unexpected weight loss. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The long term care plan identified the resident’s needs, summary of the assessments, objectives, and care requirements. The goals and what is important for the resident is recorded on the care plan. Family involvement is evident in all the files reviewed. All care plans evidenced how to manage behaviours over a 24 hour period and falls minimisation strategies. All files reviewed provided evidence that the interventions are consistent in meeting the assessed needs of the resident. The staff reported that the care plans provide guidance to the interventions required for each resident. All residents and family members reported satisfaction with the care and service delivery.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 | There are planned activities provided five days a week. The activities programme covers physical, social, recreational and emotional needs of the residents. There were diversional therapies, activities, social and cultural assessments sighted in the residents’ files reviewed. Each file reviewed had a plan of how to respond to activities for the resident over a 24 hour period. The diversional therapist reported that they gauge the response of residents during activities and modified the programme related to response and interests. The diversional therapist reported the activities were also modified according to the capability and cognitive abilities of the residents. There is appropriate access to outings. The diversional therapist receives ongoing education and attends a monthly peer group for diversional therapists in aged care. The family/whanau reported satisfaction with the activities programme. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The care plans documented the resident’s responses to interventions, with evaluation conducted at least six monthly. There is an additional summary, which reviews the overall progress of the resident in the previous six months. Where progress was different from expected, the service responded by initiating changes to the care plan or by use of short term care plans for temporary changes. Short term care plans were sighted in the files reviewed. The family/whanau reported high satisfaction with the care provided at the service. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires on 1 December 2015. The nurses’ station has glass surround and the doors into the care facility are also glass to allow maximum visibility. On night duty the doors into the wings are open to allow even greater visibility and also ensure staff can hear residents moving around. Management have looked at other options but as the facility is built to capacity they have found no further solutions to this issue raised by the DHB.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | The location of toilets is sign posted using words and pictures to make finding them easier for residents. The management are actively working on changing the colour of the toilet doors as suggested by the DHB and to date have approached a painter and the local art school to undertake this job. Flooring has been replaced and skirting board repainted in order to meet infection control standards. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Policy and daily task lists have been updated and implemented by the service to ensure cleaning processes, including the management of soiled urinary pads are managed to help prevent the smell of urine. Cleaning chemicals, which are securely stored and correctly labelled, include deodorising product. There is a regular carpet cleaning regime maintained.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The service conducts monthly surveillance for infections. The infection rates are benchmarked with an external agency. There is a two monthly infection control meeting (combined with restraint and privacy committee) which reviews any trend and discusses actions to reduce the recurrence of infections. The infection and surveillance data and infection control minutes for 2015 were sighted, confirming the actions that have been implemented to reduce chest infections and urinary tract infections.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Restraint is minimised to ensure that if deemed necessary the resident is kept safe from harm to themselves and/or others and the practice occurs in a way that is culturally appropriate, respectful and safe. Policy identifies that enablers are voluntary and the least restrictive option. The RN confirmed that no enablers can be used at the facility as residents are unable to make a meaningful decision owing to their level of dementia. At the time of audit the service has one bedside rail and one safe seat restraint in use. This is clearly documented in the restraint register and meeting minutes sighted. All documentation completed complies with policy. Staff are aware of what actions need to be taken related to the use of safe restraint.  |

# 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.