

# Chetty's Investment Limited

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Chetty's Investment Limited
<b>Premises audited:</b>	Alexander Lodge Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care); Residential disability services - Psychiatric
<b>Dates of audit:</b>	Start date: 16 September 2015    End date: 16 September 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	20

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Alexander Lodge Rest Home (Alexander Lodge) is privately owned. It provides rest home level care for up to 23 residents. The service also holds a contract for psychiatric residential disability but no residents are presently under this contract.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, family/whānau, management, the general practitioner and staff.

There were no areas identified for improvement during this audit and no areas for improvement to follow up from the previous audit.

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

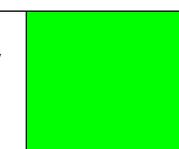
## Consumer rights

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.
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Staff communicate with residents and family/whanau members following any incident in a manner that is reflective of open and honest communication.

Alexander Lodge implements policy and procedures to ensure complaints are documented, reviewed, followed up and fully addressed. At the time of audit there are no open complaints.

## 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.
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Alexander Lodge has a business plan which covers all aspects of service delivery planning. The business plan was reviewed in June 2015. It is a 'living document' and the owner/manager updates the plan throughout the year to show service planning and coordination to meet the needs of residents.

The owner/manager works in the facility with a clinical manager (registered nurse) who oversees all clinical aspects of care. Management are supported by staff who are experienced in the age care sector.

The service has quality and risk management systems which are understood by staff. Quality management reviews include an internal audit process, complaints management, resident and family/whānau satisfaction surveys, resident meetings, incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff and residents and family/whānau as appropriate.

Good human resources practices are implemented. The staffing skills mix is appropriate for rest home care services. Every shift is covered by a staff member who holds a current first aid certificate.

As confirmed during resident and family/whānau interviews, residents' needs are met.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Pre-admission information clearly and accurately identifies the services offered. Services are provided by suitably qualified and skilled staff to meet the needs of residents. All residents admitted to the service have an interRAI assessment completed by the registered nurse clinical manager. The service meets the contractual requirements and timeframes for the development and reviews of care plans. When there is a change in the resident`s needs, a short term care plan is utilised to reflect these changes.

Residents are reviewed by the general practitioner on admission and subsequent reviews occur. Referrals to other health and disability services is planned and co-ordinated, based on the individual needs of the resident. The residents and family interviewed reported they are involved in the care planning process.

The service has planned activities and the programme is implemented. Residents are encouraged to participate in the programme and to maintain links with family and the community.

A safe medicine administration system was observed during the audit. The service has documented evidence that staff responsible for medicine management are assessed as competent to do so.

Residents` dietary requirements are met by the service with preferences taken into account. Special diets are catered for and food is available 24 hours a day. The service has a three week summer/winter menu which is approved by a dietitian. Satisfaction surveys are performed annually.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness. There have been no changes made to the building footprint since the previous audit.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are no restraints or enablers in use at Alexander Lodge. This is reflected in policy. Enablers are described as voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the bi-annual education planning process.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The service maintains a monthly surveillance programme where infection information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported back to staff at the staff meetings. Surveillance is adequate for the size and nature of this service.

## 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)
<b>Standards</b>	0	18	0	0	0	0	0
<b>Criteria</b>	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Complaints management is implemented to meet policy requirements. The complaints register sighted identified the issue, the date received and the date the complaint was closed off. All complaints sighted were of a minor nature. There are no open complaints at the time of audit.</p> <p>The owner/manager confirmed complaints management information is used as an opportunity to improve services as required. Management and family/whānau interviews, confirmed that complaints management was explained during the admission process. Staff verbalised their understanding and correct implementation of the complaints process. Complaints are a standing agenda item for staff meetings. The most recent newsletter sent to family/whānau and given to residents contained information related to the complaints procedure and reminded everyone that it is their right to make a complaint.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>The registered nurse and general practitioner interviewed confirmed they communicate in an open and honest manner. The principles of the open disclosure policy documented and reviewed are adhered to. Residents and their family/whānau members are consulted, included and involved in care provision changes and review processes. Communication with family/whānau documentation was sighted in all residents` files reviewed.</p> <p>Incident/accident forms identify family/whānau are informed when an incident occurs and this is also documented for all incidents where this was sampled.</p>

conducive to effective communication.		Interpreter/translation service contact details are available if and when required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The business and quality plans for Alexander Lodge are reviewed annually. This process last occurred in June 2015. The organisation's goals and direction are described in the business plan and as each goal is attained it is documented and signed off by the owner/manager. The mission statement is clearly identified and underpins the direction of the organisation. Specific plans, aims and ambitions are documented for 2015 and signed off when completed by the owner/manager.</p> <p>On the day of audit there were 20 rest home level care residents. No current residents are under the psychiatric residential disability contract.</p> <p>The owner/manager has operated the business for the past three years. He is assisted by a clinical manager who is a registered nurse. They attend regular professional educational forums and are both interRAI trained. The clinical manager's job description identifies her authority, accountability and responsibility for the provision of services.</p> <p>Interviews with residents and family/whānau members confirmed that their needs were met by the service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality and risk management system documented is understood and implemented by service providers. These processes include regular internal audits, incident and accident reporting and analysis, health and safety monitoring, infection control management and data recording and complaints management processes. If an area of deficit is found corrective measures are put in place to address the situation. This process is well documented. Information is shared with all staff as confirmed in meeting minutes and verified by staff during interviews. Meeting minutes show clearly documented quality actions and outcomes. The quality data gathered is reported to staff in a manner that is easily understood and shows comparisons from previously collected data. The organisation has a contracted dedicated quality person to assist with this process.</p> <p>Resident meetings are used as a forum to indicate resident satisfaction of services offered. All service delivery issues are discussed and followed up as required. The minutes sighted indicated resident satisfaction with the services offered. This is also supported by the results of the 2014 satisfaction survey sighted.</p> <p>Information gained by the quality processes undertaken is used by the owner/manager to inform ongoing service planning and to ensure residents' needs are being met. Corrective measures sighted are signed off by the owner/manager and/or the clinical manager following implementation. For example, a deficit was discovered during the internal file audit review. This related to the information about enduring power of attorney. Any residents who did not have this information on file were followed up by the clinical manager. It involved family/whānau being contacted. The file reviews undertaken during audit found all processes were completed.</p>

		<p>The service uses specific corrective actions form so all follow up can be audited.</p> <p>Actual and potential risks are identified and documented in the risk register which covers all aspects of service provision. Newly identified hazards are documented using a specific form to show how the hazard is managed. All hazards are reviewed at least annually and this last occurred in January 2015. Hazards are communicated to staff, family/whānau and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p> <p>Residents and families/whānau interviewed confirmed they are happy with the services provided. Staff verbalised quality improvements and how they have been embedded into everyday practice.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Policy is implemented related to all adverse events reporting and recording. The service uses incident and accident forms. All forms are reviewed by the clinical manager and the owner/manager in a timely manner. Staff interviewed confirmed they report and record all incidents and accidents.</p> <p>Documentation confirms that information gathered from incidents and accidents is used as an opportunity to improve services where indicated. One example relates to ongoing staff education on correct positioning of a resident when they are in bed to prevent falls. This occurred after the resident slipped out of bed twice in a month. Since the education occurred no further incidents have been recorded.</p> <p>Incident and accident information is reviewed, documented, analysed and reported at management and staff level each month. Corrective actions are undertaken as required.</p> <p>The owner/manager and the clinical manager confirm their understanding related to the obligations in relation to essential notification requirements.</p> <p>Family/whānau members interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relative. This is supported during a review of incident and accident forms and residents' file reviews.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of</p>	FA	<p>Policies and procedures identify human resources management practices, that reflect good employment practice and meet the requirements of legislation, are implemented by the service. Upon employment, referees are checked and job descriptions clearly describe staff responsibilities and accountabilities. Staff files reviewed identify that staff have completed an orientation programme with specific competencies for their roles. Staff annual appraisals are up to date.</p> <p>There is a two yearly education calendar which identifies the education undertaken by staff covers all aspects related to care provision. Education includes guest speakers and staff have the opportunity to attend off-site seminars and training days related to the roles they undertake. This was confirmed in the education records</p>

<p>legislation.</p>		<p>sighted in staff files and on an electronic data base kept up to date by the clinical manager.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.</p> <p>Resident and family/whānau members interviewed identified that residents' needs are met by the service in a professional manner.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy related to staff skill mixes and experience is reflected in the roster and meets contractual requirements. Every shift is covered by a staff member with a current first aid certificate.</p> <p>A review of the roster showed that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed they have adequate staff on each shift to allow all tasks to be completed in a timely manner and that resident' needs are met. This is supported by resident and families/whānau interviewed.</p> <p>The clinical manager works Monday to Friday and is on call. The owner/manager is available at any time. Owing to the size of the facility some staff undertake several roles, such as the activities coordinator also working as a health care assistant, there are dedicated hours identified for each role. This is identified in each staff member's file with appropriate signed job descriptions. There is dedicated kitchen staff.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>All transfers and discharges are arranged in collaboration with the resident and family/whanau of choice. The DHB yellow bag system protocol worked effectively to ensure all relevant information is provided about a resident when transferred to the DHB or to another service provider in the community. The service planned referral form sighted contains evidence of the doctor's letter, x-ray results if required, higher user health and/or community services card details, mental state, personal care requirements, bladder/bowel function, mobility status and any other additional informational. Any risks are minimised and transfers are arranged safely. Transport is arranged accordingly to suit the nature of the transfer. With consent the family/whanau are advised and kept well informed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current</p>	<p>FA</p>	<p>The medication policies and procedures are available to guide staff. The policies clearly describe the processes to ensure safe administration of all medications. This includes competency requirements prescribing by the GP, recording, and processes when an error occurred. The sighted policies and procedures meet legislative requirements and best practice guidelines. The GP was interviewed and stated that a safe medication management system is implemented efficiently by all staff involved. The contracted pharmacy performs a six monthly pharmacy audit and there is evidence of medication reconciliation.</p>

<p>legislative requirements and safe practice guidelines.</p>		<p>The registered nurse clinical manager and seven caregivers have completed medication competencies annually. Medications are received from the contracted pharmacy in a pre-packed delivery system and stored safely. The medication round at lunchtime was observed and was managed safely. Controlled drugs are checked weekly and the register was reviewed. The checks were documented in red ink and balances were true and correct.</p> <p>The medication records are reviewed by the GP three monthly or more often if required and the records are signed off and dated. Each medication is individually prescribed. A specimen signature list of medication administrators and the GP was maintained. All medicine charts reviewed have a photo of the resident to assist with identification of the resident. Medicine signing sheets are generated from the pharmacy. Any alerts/allergies/sensitivities are documented in red ink.</p> <p>No residents currently self-administer medications. A policy for self-administration of medication is in place should this be required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food handling policy has been reviewed. Procedures are documented which include best practice guidelines for kitchen cleaning, temperature monitoring requirements, hygiene standards for staff, checking, storage and waste handling. Regular monitoring and surveillance of food preparation and hygiene is carried out effectively.</p> <p>There is a three week menu rotation of summer and winter plans. There is evidence of dietitian input. Breakfast is prepared in readiness by the night duty staff and served by the morning caregivers in the dining room. The main meal is served at lunchtime and this was observed in progress. Residents interviewed reported that they enjoyed the meals. A list of residents` preferences is documented and is accessible for the cook.</p> <p>An individual nutritional profile is completed for each resident during the admission process. The registered nurse notifies the cook of any special diets or other identified needs required. Special equipment can be arranged if needed for a resident.</p> <p>The service manager is responsible for purchasing the food and checking of deliveries. The cook has to prepare and cook all meals and is responsible for the cleaning of the kitchen. The cook worked a split shift to cover all meal times. Snacks are available 24 hours a day. The cook has undertaken food safety management education appropriate to service delivery.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are</p>	<p>FA</p>	<p>The residents' records sampled and reviewed have activities plans and care plans that address the individual resident`s current abilities, level of independence, identified needs/deficits, and takes into account the resident`s habits, routines and idiosyncrasies. The strategies for minimising falls and encouraging activities are documented. The caregivers interviewed are skilled and demonstrated knowledge on these strategies. Short</p>

<p>consumer focused, integrated, and promote continuity of service delivery.</p>		<p>term care plans are available with goals and interventions to meet the goals set.</p> <p>The samples of resident records reviewed are consumer focused, integrated and promote continuity of service provision.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Clinical management policies and procedures include the interRAI assessment on admission, weight and bowel management, clinical records and referral information. As observed on the day of the audit and from review of the care plans, support and care was flexible, individualised and focused on the promotion of quality of life.</p> <p>The registered nurse and caregivers interviewed demonstrated appropriate skills and had good knowledge of the individual needs of the residents.</p> <p>The resident's individual records showed evidence of consultation with and involvement of family/whanau. The residents and family members interviewed reported satisfaction with the care and services provided.</p> <p>There is evidence of short term plans for any event that is not part of the long term care plan. The short term care plans sighted were for behavioural issues and weight loss management.</p> <p>There are adequate dressing and continence supplies to meet the needs of the residents.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>One activities coordinator was available for interview. The activities observed in action give residents a sense of purpose, belonging and meaningful activities and are reflective of normal life interests. The activities coordinator reported flexibility of the programme to meet the needs and choices of residents. The activities are planned monthly but displayed weekly. The programme reflected interests, skills and strengths of the residents. Most activities are provided in the main lounge and dining area. Outings into the community are encouraged with the use of the rest home seven seater van which also has a wheelchair hoist if required. Residents are able to be transported to appointments if needed. Legislative requirements for the rest home van are planned and monitored by the owner director.</p> <p>The activities coordinator maintained a daily activities attendance record which was sighted. The resident activities plans are reviewed six monthly or more often if required. The goals are updated after discussion with the residents and staff. Residents are encouraged to maintain links with family and the community. Families are encouraged to be involved.</p> <p>The residents/family interviewed reported that they enjoyed the range and variety of the activities provided and all cultural needs are able to be effectively met.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents' records reviewed had an evaluation conducted in the last six months. Evaluations are resident focused and indicate the degree of achievement or responses to supports/interventions and progress towards meeting the desired outcomes. If a resident is not responding to the service/interventions being delivered, or the health status changes, then this is discussed with the general practitioner (GP). The GP interviewed stated that staff contact is appropriate and timely when changes occurred.</p> <p>Short term care plans are utilised as required. These plans are clearly documented on the short term care plan and updated until they are closed out effectively.</p> <p>The caregivers interviewed reported that they notify the registered nurse clinical manager if there are any concerns or changes observed in a resident's condition. The registered nurse is on 24 hour call Monday to Sunday and reports this arrangement worked efficiently for this service. There is GP coverage 24 hours a day seven days a week. The GP visits routinely three monthly or more frequently as required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Documentation identifies all processes are maintained for the facility's current building warrant of fitness which expires on 9 February 2016. There have been no changes made to the footprint of the building since the previous audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection control surveillance that is undertaken is appropriate to the size and complexity of the services provided as shown in the infection control programme. All staff are responsible for surveillance activities. Monitoring is described in the surveillance plan and management meetings. Any trends identified are reported to staff at the staff meetings. Minutes are available and sighted of the meetings held. Safety of residents is paramount. The infection control surveillance programme is managed effectively by the registered nurse clinical manager.</p> <p>A monthly infection surveillance report is available. Monthly statistics are collated and individually identified to identify any trends.</p> <p>There have been no outbreaks of infection since the last audit.</p> <p>Any information of known infections are communicated to the DHB if and when transferring a resident to another health and disability service and the DHB would inform the service provider, should this be applicable for a resident transferring to the facility. Staff interviewed have a good understanding about infection control</p>

		and good hygiene practices. Hand- washing and the use of personal protective equipment was observed and is encouraged at all times. Resident education (significance of hand-washing) is part of the infection surveillance programme.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy identifies that the use of enablers are voluntary and the least restrictive option to meet the needs of the resident. It also identifies that the service operates a restraint free facility.</p> <p>Alexander Lodge had no enablers or restraints in use at the time of audit. Staff confirmed during interview that no restraints or enablers are used and verbalised their understanding of both restraint and enabler processes should they ever be required.</p> <p>It was noted by the owner/manager that not all relatives understood restraint use. The reason the facility remains restraint free was explained in a newsletter sent to all relatives that stated that residents are encouraged to be as independent as possible and to maintain their contacts and interests in the community. Residents were observed going out independently to the shops and community clubs on the day of audit.</p>

## Specific results for criterion where corrective actions are required

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Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.