# The Ultimate Care Group Limited - Allen Bryant Lifecare

## 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:** The Ultimate Care Group Limited

**Premises audited:** Ultimate Care Allen Bryant

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 25 January 2016 End date: 26 January 2016

**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:** 40

# 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** |
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|  | 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

Ultimate Care Allen Bryant in Hokitika on the West Coast is certified to provide rest home and hospital level care for 46 residents. On the day of this announced surveillance audit there were 40 residents. This consisted of 13 rest home residents, 23 hospital residents and four young persons with a disability.

The governing body is Ultimate Care Group Limited. The Facility Manager and Clinical Services Manager oversee the day to day management of the facility, and are supported by the organisation’s management group, one of whom was present on the day of the audit.

The audit against the Health and Disability Services Standards and the providers contract with the district health board, included observation of the environment, interviews with the management team and staff, review of documentation and interviews with residents and their families.

The two areas identified as requiring improvement at the previous audit have been addressed. No other areas were identified as requiring improvement.

## Consumer rights

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

Residents and families interviewed reported that communication is excellent. They have a clear understanding of their rights and the facility’s processes if these are not met. The complaints process is well managed within required timeframes and includes the principles of open disclosure.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The organisation’s quality plan is current and documents the facility’s purpose, values, scope, direction and goals. There is evidence that the Facility Manager and Clinical Services Manager have the relevant experience and skill to manage the facility.

There is a defined document control system. Accidents and incidents are being reported and analysed and an internal audit programme is maintained to ensure that required standards are being upheld. Corrective action plans are in place for areas of non-compliance.

A comprehensive induction and orientation programme is in place, and the related documentation, including annual appraisals has been completed. A planned training programme guides all staff, including professional development for registered nurses (RN) which is well supported by the organisation. The roster indicates that staffing levels are safe and that there is a RN on duty at all times.

## Continuum of service delivery

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| 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. |

A RN develops a detailed care plan based on the interRAI and other assessments to guide staff in service provision, and reviews these within recommended timeframes.

Observation of care staff, review of residents’ notes and resident and family interviews, confirmed that all staff provide individualised care that reflects the residents’ needs. A general practitioner (GP) was interviewed during the audit and confirmed the facility provides a high standard of care and her recommendations and treatments are carried out. There was evidence in files reviewed that the GP visits three monthly if the resident is assessed as clinically stable. Two residents were reviewed in detail using tracer methodology confirming the facility’s processes are being met.

An activities programme is planned and implemented by the activities person and it was confirmed by residents and family members that this is age appropriate and of interest to them. Individual activity plans now reflect the resident’s interests meeting a previous shortfall.

Policies and procedures are in place for all stages of medication management. A blister pack medication system is in use for the facility. The medication administration process was observed during the audit confirming safe practice occurs. Documented medication records are completed and reviewed by the resident’s GP. Controlled medicines are secure and meet recommended guidelines for storage and monitoring.

A dietary profile is completed for each resident on admission and any special dietary needs are met. Personal likes and dislikes are catered for. The kitchen service is managed from within the facility by the chef who is supported by kitchen staff. A nutritional review of the menu has occurred in the past 12 months and, as observed, the meals reflect the menu. Appropriate monitoring of food procurement, transportation and storage of food occurs. Food waste is disposed of according to guidelines meeting a previous required improvement.

## Safe and appropriate environment

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| 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 facility has a current building warrant of fitness, fire service approved evacuation plan and regular fire drills are occurring. All building plant and equipment are regularly tested.

The facility has been completely refurbished after flooding, evacuation and temporary closure in June 2015. All bedrooms have new furnishings and are personalised. One previous bedroom is now the whanau room and the whanau room is a bedroom. Call bells are available in all resident care areas. There are internal and external communal areas for residents to use, with no evidence of the June floods.

Fire and emergency management systems are in place and the organisation has access to a generator in the event of a power failure. There are adequate provisions of resources for residents and staff in the event of an emergency. As an initiative following the emergency a storage of water is kept in every bedroom wardrobe.

## Restraint minimisation and safe practice

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| 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. |

A documented restraint and enabler use policy is in place and meets the standard requirements. At the time of audit there are no residents with either enablers or restraints in use.

## Infection prevention and control

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| 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. |

Surveillance of infections is occurring and infection control and prevention data is collated and analysed with the aim of minimising infections. The organisation’s electronic reporting system is utilised at the facility.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| **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 | 21 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 51 | 0 | 0 | 0 | 0 | 0 |

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| **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).

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| **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 organisation’s complaints policy, which meets the requirements of Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code), is in place. Staff interviewed were aware of how to assist residents and family if they wished to make a complaint. Complaints are on the monthly staff meeting agenda, with complaints identified and the resolution or on-going process included. This was confirmed in the complaints log. Two complaints have been documented on the complaints register for 2015, and both have been closed out.  Residents and family interviewed confirmed that the complaints process is easily accessible. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Guidelines are in place for communicating with residents and visitors. During the audit staff were observed addressing people in a respectful manner and residents were being given time to answer. Residents and family members interviewed reported that staff take time to make sure that they are understood and communication is always very respectful.  Open disclosure occurs according to the organisation’s policy, and this is verified in family and resident interviews and in three incident reports sighted.  Interpreter services are available for any resident who requires this. No residents have required this service since the previous audit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Ultimate Care Group’s mission statement includes the purpose of the service and strategic links to deliver an overall vision to Ultimate Care Allen Bryant. A list of key performance indicators (KPI) are included, with documented actions on how these will be met. There have been recent organisational management changes that are reflected in the quality plan.  The Clinical Services Manager (CSM) and the Facility Manager (FM) have been in their current roles since 2008 and have the relevant experience and qualifications, including recent educational updates.  Oversight is provided by the Ultimate Care Group Limited (UCG) Audit and Compliance Manager who was present at the audit. All are supported by head office of the UCG.  The CSM and FM report to the organisation and head office at teleconference session on a weekly basis, as evidenced in documentation. |
| 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 improvement principles. | FA | An organisation wide quality management and risk management policy (2015-2016) includes key responsibilities in all services areas for Ultimate Care Allen Bryant in Hokitika. The quality programme clearly documents the expectations of the organisation linking to the quality and risk management system, and is consistent with the organisation’s overall vision.  There is a detailed flow of responsibilities throughout, and leading up to the governing body. New appointments have been flagged for April to include the appointment of a new Chief Clinical Officer as providing clinical oversight for the whole organisation.  Documents are reviewed every two or three years, as sighted in a staggered document control process, and all sighted were current.  Monthly management and regional meetings include all risk areas as agenda items. Identified risks are transferred to an electronic reporting and analyses system. These are reported back to the facility with recommendations to minimise risks.  Minutes of meetings from the past three months were sighted. Feedback from the meetings is passed onto staff via monthly meetings and on displayed notices.  A corrective action plan is implemented for those areas that do not meet pre-determined criteria. At the time of the audit all corrective actions have been closed out.  There is an internal audit programme completed on all areas of service delivery. Results are reported to head office, management and staff meetings on a monthly basis. |
| 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 | Incidents are being reported on a form intended for the purpose. Staff interviewed demonstrated awareness of the reporting requirements for adverse events and confirmed they use the form and process when appropriate.  The information on the forms is used to address the issues as they arise and the forms show the CSM is signing them off following review of the incident and taking appropriate action.  Incidents are an agenda item at management meetings where they are discussed. Incident data is being collated and documented on the organisation’s electronic register.  The CSM and FM interviewed were aware of their statutory obligations in relation to essential notification, including grade 3 and above Pressure Injuries. An example was provided of a recent case when the service had flooding. |
| 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 | Records were sighted of annual practising certificates for all registered nurses (RN), enrolled nurses (EN) and one GP.  An induction and orientation programme that covers key information and safety topics is documented in the organisation’s policies and procedures. Orientation records were on file for all of the seven staff whose files were reviewed.  A staff training programme was sighted. Monthly educations sessions are held. Staff interviewed reported they are provided with training on topical issues, with an example being challenging behaviours. External training, such as the interRAI assessment tool use, is provided for RNs.  All RNs and other key staff, such as activities staff, have a current first aid certificate.  Care staff are at different levels of attainment of certificates through the Aged Care Education (ACE) programme. Those at senior level have completed level three and dementia care. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a staffing and skill mix policy that reflects the mix of staff as documented on the facility’s roster. At least one RN is on duty at all times as specified in the roster. The CSM and FM share on call duties.  New staff reported that they always work with a senior staff member until deemed competent, but that all care staff work in teams, with a team leader who is an experienced staff member. Staff files verify that senior staff have the necessary competencies.  A roster for two weeks was sighted and meets with the minimum requirements.  Residents, family members and staff interviewed reported that there are sufficient staff on duty to meet the needs of residents. |
| 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 | Routine medications are supplied by the pharmacy in a blister pack administration system. The medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident. In the hospital wing a standard small supply of medications are available for urgent situations. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered.  The GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists.  Safe medicine administration was observed at the time of audit. All records were accurately completed.  Medications were seen to be securely stored, and at appropriate temperatures. Controlled medications were checked according to medication guidelines, including pharmacist checks.  All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. Each medicine was signed by the GP and had the required level of documentation to allow safe administration of the medicines. The prescriptions were legible, recorded the name, dose, route, strength and times for administration. The medicine charts recorded the regular, short course and pro-re-nata (PRN – as required) medicines for each resident.  When medicines were discontinued, these were signed and dated by the GP. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification was recorded for all staff who administer medicines. All of the medicine charts were reviewed by the GP in the past three months, except those of recent admissions.  Medication competencies were sighted for all staff that assist with the medicine management; this included the RNs.  There were no residents who self-medicate, although there are processes in place should this occur. |
| 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 | The current menu was reviewed by a dietitian as being suitable for the older person living in long term care. The same menu is used throughout the organisation. If there are changes to the menu these are recorded and referred to the dietitian at the next review. The chef in charge of the kitchen has been at the facility for over 10 years and has had a recent food hygiene education update. All residents interviewed reported satisfaction with the food and food services.  Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets had these needs met.  There is food available 24 hours a day for those who wish to snack at night.  All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. This meets a previous required improvement relating to food waste disposal.  Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. |
| 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 provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. The care plans reviewed were individualised and personalised to meet the assessed needs of the resident. The care was flexible and focused on promoting quality of life for the residents. Two residents with recently healed pressure injuries (PI) had appropriate interventions in place and these were reassessed regularly. All residents and family interviewed reported great satisfaction with the care and service delivery. |
| 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 activities programme is developed individually and as a group to meet the social and recreational needs of the residents. The group activity programme is developed monthly. The residents are included in activities at the facility and as part of the wider community. Feedback is sought from residents during activities, and at monthly resident meetings. The activities person reported that he gauges the response of residents during activities and modified the programme related to response and interests. He has recently been appointed to the role and has enrolled in a diversional therapy course.  Activity plans are individualised and reflect resident’s current interests, for example attending a community group. This previous required improvement has been met  Residents and family reported a high level of satisfaction with the care and therapy provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All the care plans sighted were developed, reviewed and evaluated at least six monthly.  Files reviewed included short term care plans in place for issues such as wound care, urinary tract infections or suspected cold/flu symptoms.  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. Two files reviewed had a short term care plan for a wound, and a separate wound care chart. These were both reviewed regularly to reflect the progress of the wound.  Residents and families interviewed reported a very high satisfaction with the care provided at the service. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | A waste management policy is available to staff. The disposal of waste, infectious and hazardous substances is being managed according to identified legislative and local council requirements. Recycling and general waste wheelie bins are put out for weekly collection and a contractor may be called to dispose of additional waste.  Personal protective equipment including plastic aprons, disposable gloves, masks and protective eye goggles are available throughout the facility. Staff were observed to be using these and during interview spoke of reasons why it was important to protect themselves.  There is no evidence of post flood waste as this was disposed of during renovations after the flood. |
| 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 Warrant of Fitness was sighted with an expiry date of 22 July 2016. All associated systems and plant were reviewed as part of this process and verified as compliant, as most of the equipment was new.  The physical environment has been completely refurbished since a flood in June 29 2015. The refurbishment has maintained a safe environment, with non-slip surfaces in bathroom areas, handrails along hallways, with space in all areas for people to mobilise independently.  Residents and family members informed they like the environment and are glad to be ‘home’.  External areas at the front of the facility and at the side entrance provide safe access to and from the expansive outdoor areas surrounding the building. The internal garden area has easy access into the facility. The gardens are well maintained. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers 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 | There is an adequate numbers of toilets and shower facilities for all residents with two sets of two rooms with a shared ensuite. There is toilet facilities close to communal and dining areas for ease of access for residents. Separate staff and visitor toilet facilities are available. All have been refurbished since the July 2015 flood. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All rooms are of a similar size rooms being of an adequate size for the resident and an assistant and aid to move around. Since the flood the whanau room is now a bedroom, and the size meets requirements, and the much larger double bedroom is now a whanau room.  Rooms were seen as being personalised by the resident and their family members to the degree they wish. Family and residents spoke of how this is a gradual process since items had been lost during the flood, but were happy with how this has been manged by the facility. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are two large lounges and other smaller areas where groups of residents and their visitors can sit. Activities were observed being carried out in two lounge areas while other residents were sitting in other areas.  Two spacious dining areas were seen in use and the CSM spoke of residents sitting where they wished to but some residents being seated in an area that maintained their dignity while eating.  Since the flood the lounge and dining areas are all completely refurbished including new furniture complimentary to the needs of the residents. |
| 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 fire service approved evacuation plan and fire drills were seen as occurring six monthly, except when the facility was closed for floods in 2015. Training on emergency occurs as part of orientation and on an on-going basis, as was sighted in staff files reviewed.  There is a standby generator available for use at the facility, and an extensive supply of emergency resources available.  A store of food and water is available. Three litres of water is also stored in each resident’s bedroom wardrobe as part of an initiative following the flood.  Call bells and an emergency bell are available by patients’ beds, toilets and lounge / dining areas. When activated the area is displayed on screens throughout the facility. There was evidence during the audit of call bells being responded to quickly.  Security is by all staff ensuring all doors are locked and windows closed before dark. External lights provide light at night. There have been no recent security issues. |
| 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 CSM holds the role of infection prevention and control coordinator. The job description for the infection control coordinator role is clearly defined. There are clear lines of accountability for infection control matters at the service through the staff meetings, and relevant information is provided to the organisation via their electronic system.  Results of surveillance are documented, analysed and a report included at staff and management meetings. This includes specific recommendations for minimising infections. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | A documented restraint and enabler use policy is in place and meets the standard requirements. The facility uses enablers, such as bedrails, if required. At the time of audit there are no residents with either enablers or restraints in use at the facility. |

# 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.

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| No data to display |

End of the report.