

# Udian Holdings Limited - Glencoe Resthome

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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>	Udian Holdings Limited
<b>Premises audited:</b>	Glencoe Resthome
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 2 December 2020      End date: 2 December 2020
<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>	13

# 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

Glencoe Rest Home is one of two facilities owned by this owner. Glencoe Rest Home provides rest home level care for up to 15 residents. There are 13 residents receiving care at audit.

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, a review of resident and staff files, observations, and interviews with residents, family members, the registered nurse, staff, facility manager and the general practitioner. Feedback from residents and families/whānau members was positive about the care and services provided.

The one area requiring improvement from the previous audit was assessed and those non-conformances have been addressed. No new areas requiring improvement were identified.

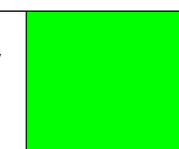
## Consumer rights

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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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained with complaints resolved promptly and effectively.

## 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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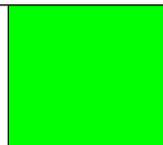
Business and quality and risk management plans include the scope, direction, goals, values, and mission statement of the facility. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified, and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

## 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.

Each stage of service provision is managed by suitably qualified personnel who are competent to perform the function they manage.

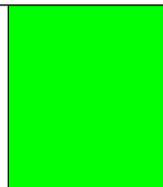
Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis.

The planned activities provide residents with a variety of individual and group activities and maintains their links with the community. Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## 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.

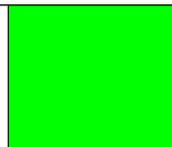


Standards applicable to this service fully attained.

There is a current building warrant of fitness.

## 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.

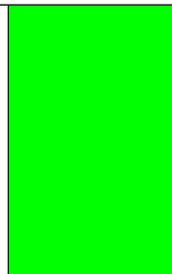


Standards applicable to this service fully attained.

The facility has implemented policies and procedures that support the minimisation of restraint. At the time of audit, the facility was restraint free. There is a comprehensive assessment, approval and monitoring process identified in policy should restraint be required. Policy states that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The infection surveillance undertaken is appropriate for the size of the facility. Infection results are reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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	16	0	0	0	0	0
<b>Criteria</b>	0	41	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that there were five verbal complaints received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. The majority of these in-house complaints related to meal service, miscommunication with a staff member and an item that was identified as lost but then found in the residents' room. Action plans showed any required follow up and improvements have been made where possible. The manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from the District Health Board, Ministry of Health or Health and Disability Commissioner since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which are supported by policies and procedures that meet the requirements of the Code.</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Staff knew how to access interpreter services. At the time of audit there was one resident that understood English but was unable to have conversations in English. Staff and family were available to translate when required. One resident has impaired vision, is supported by an electronic reading book apparatus, and is regularly visited by the blind foundation. This information, equipment, resources and allied support was evidenced in the residents' long-term care plans. Residents and family interviewed were happy with the support provided.</p>
<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>	<p>FA</p>	<p>Glencoe Rest Home has a documented mission statement, philosophy and values. The manager lives on site and is confirmed being readily available to residents and family.</p> <p>The manager monitors the progress in achieving goals via day to day activities, resident / family feedback and monitoring of the results of quality and risk activities. The manager has worked at Glencoe since the owner / director purchased the rest home; and prior to this has worked in a range of information technology / communication roles both in New Zealand and overseas. The manager participates in relevant ongoing education as required to meet the provider's contract with Counties Manukau District Health Board (CMDHB). When required due to Covid-19 restrictions meetings and education occur online.</p> <p>Since the last audit bedrooms continue to be re painted and there are plans for 2021 for an existing toilet to be converted into another shower room (see criterion 1.4.2). This aligns with facility goals.</p> <p>Prior to Covid-19 a registered nurse was supporting both Glencoe Rest Home and its sister facility. A bureau registered nurse was employed on the on the 18 August 2020 to solely support Glencoe while awaiting the commencement of a new registered nurse. The current experienced registered nurse was employed on the 10 September 2020 and is responsible for the clinical services provided only at Glencoe Rest Home. She works 32 hours a week on site, normally Monday, Tuesday, Thursday and Fridays. The RN is on call at all times when not on site. The RN has a current annual practising certificate (APC), and on the day of audit was due to complete interRAI training which has now been rebooked. In the interim the RN (from Glencoe's sister facility) continues to be contracted to assist with InterRAI assessments. The hours worked depends on the number of new residents and number of residents requiring review. The hours for interRAI assessment were additional to the employed RN hours.</p> <p>The service has a contract with CMDHB for the provision of aged related long-term support, chronic health conditions and residential and respite services. All residents have been assessed as requiring rest home level care. This includes one resident under the care of the DHB mental health services.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, and clinical incidents including infections.</p>

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at monthly management team meetings/quality meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and discussions in staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident/family satisfaction surveys are completed yearly. The most recent survey in June 2020 received feedback from four residents. The survey results reviewed by the auditor did not raise any concerns with feedback received showing that overall residents and family were very happy with the care and services provided.</p> <p>The previous audit identified an area for improvement to ensure that policies were reviewed regularly and cover all necessary aspects specific to the service and contractual requirements. The corrective action is now addressed, and records were available to demonstrate that policies are have been reviewed, are based on best practice and were current and specific to the service. The document control system ensures a systematic and regular review process, referencing of relevant sources which included the interRAI Long Term Care Facility (LTCF) assessment tool and process, approval, distribution and removal of obsolete documents.</p> <p>The manager and registered nurse described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies and are both familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed by the registered nurse and reported to the manager.</p> <p>The registered nurse and manager described essential notification reporting requirements, including for pressure injuries. Emails evidence that the CMDHB were notified of the two registered nurse changes on the 19 August 2020 and again on the 28 September 2020. A section 31 re: notification of change of clinical manager/RN was sighted and sent on the day of audit. There have been no police investigations, coroners' inquests, issues-based audits or public health notifications made since the previous audit.</p>
<p><b>Standard 1.2.7: Human Resource</b></p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period. Continuing education is planned on an annual basis, including mandatory training requirements.</p> <p>The newly appointed registered nurse was fully orientated remotely (due to Covid-19) and documentation was sighted to evidence this including medication competency. The registered nurse continues to be externally supported as required by the registered nurse residing at Glencoe's sister facility. Glencoe Rest home was visited by the clinical nurse specialist and director of nursing for Counties Manukau District Health Board (CMDHB) and met with the registered nurse and manager on the 14 October 2020. The registered nurse is aware of online support training and will attend training and aged care meetings with CMDHB once they resume.</p> <p>All care staff have been employed having an equivalent qualification that meets that meet level two requirements of career force New Zealand Qualification Authority education programme and the requirements of the provider's agreement with the DHB. The manager interviewed stated that she is currently working with career force to support the care staff to move forward with their career force training. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents, with staff reporting that good access to advice is available when needed by the registered nurse and manager. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Observations and review of the roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate which also includes the registered nurse and manager.</p> <p>A dedicated Covid-19 preparedness plan was evidenced which identified interventions that were in place to reduce and minimise the risk of infections and included action plans that would be implemented if an event occurred which included staffing/roster, residents/visitors, hygiene and infection control plans for different alert levels, and a dedicated isolated area. Training records were sighted showing training supporting staff and their knowledge about Covid-19. Training included practices/process and particularly the isolation set up eg: gowns/masks/gloves donning and doffing areas, cleaning, and infection control. The manager reported that Glencoe Rest Home completed a zoom meeting with the clinical nurse specialist from Counties Manukau District Health Board on the 17 April 2020. At the time of audit, the rest home had not received a documented outcome of this meeting.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>Glencoe uses a paper-based medicine management system. The RN was observed administering medicines. They demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines have current medication administration competency.</p> <p>The contracted pharmacy supply medicines in pre-packaged format. The RN checks medications against the prescription when they are delivered from pharmacy. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>There were no controlled drugs stored on site on the day of the audit. There is an appropriate system for controlled drugs storage that is in accordance with legislative requirements. The previous entries in the controlled drug register provided evidence of weekly and six-monthly stock checks.</p> <p>The medication charts reviewed included the GP's signature and the dates for commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. Three-monthly medication reviews were completed consistently.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner when required. There is an implemented process for comprehensive analysis of any medication errors.</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 service is provided on site by trained caregivers and is in line with recognised nutritional guidelines for older people. All staff who work in the kitchen have received training on safe food handling training. The menu follows a six-weekly cycle and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Copies of diet profiles for all residents were kept in the kitchen</p>

		<p>folder, and any changes are made known to the kitchen staff. Nutritional supplements are provided to residents as required.</p> <p>Interviewed residents confirmed satisfaction with the meals provided. Reviewed satisfaction surveys and resident meeting minutes verified this. Residents were given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>	FA	<p>Care provided to residents was consistent with their assessed needs, goals and the plan of care. This was verified by documentation, observations and interviews conducted with residents and family. Residents' individualised needs was evident in all areas of service provision. The GP verified that medical input was sought in a timely manner, that medical orders were followed, and care provided was appropriate. The caregivers confirmed that care was provided as outlined in the documentation. Appropriate equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs.</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>	FA	<p>A social history assessment is completed on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. Daily attendance records were completed and data from these was used as a basis for evaluation of participation. Reviewed activities plans were evaluated six -monthly as part of long-term care plan evaluation.</p> <p>The activities programme is provided by an activities coordinator with the support of all staff when required. The planned activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Activities on the programme included: bowls, card games, exercises, movies, music, birthday celebrations, coffee on the deck, monthly theme celebrations and happy hour. Residents can attend to church services in the community if desired and they are escorted by their family or church groups. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents were participating in a variety of activities on the day of the audit. Residents and family interviewed confirmed they find the programme satisfactory.</p>
<p>Standard 1.3.8: Evaluation Consumers' service</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes by the caregivers. If any change is noted, it is reported to the RN. The RN reviews and document in the progress notes at least weekly and more frequently when indicated as determined by the resident's condition.</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>The reviewed records showed that formal long-term care plan evaluations occur every six months following the six-monthly interRAI reassessments, or as residents' needs change. The evaluations indicated the degree of achievement or response to the interventions and/or support provided, and progress towards meeting the desired outcome. Where progress was different from expected, the service responded by initiating changes to the plan of care.</p> <p>Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated. Short term care plans sighted were for urinary tract, chest infections and weight issues. The RN reported that unresolved conditions are added to long-term care plans. Residents and families/whānau interviewed confirmed their involvement in evaluation of progress and any resulting changes.</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>The facility has a current building warrant of fitness expiry 16 March 2021 which is publicly displayed. No changes have occurred to the facility with the exception of some renovation / refurbishment activities. The fire evacuation plan has not required amendment. The residents have access to one shower room. A document dated 15 July 2020 was sighted showing plans to renovate an existing toilet into another shower (see criterion 1.4.2). Each of the bedroom's residents have a hand basin with access to pump soap bottles and a linen towel which is removed and washed daily or earlier if required. The manager interviewed stated that they will be implementing wall mounted paper towel and soap dispensers for the resident's rooms in 2021. There is hand sanitiser mounted to the walls throughout the corridors and individual pump hand sanitiser bottles were sighted in the lounge, dining area, kitchen and on the medication and dressing trolleys. The facility has five toilets. Paper towels and soap dispensers were sighted on the walls of these rooms. There are also hand basins with supporting paper towels and soap dispensers in the kitchen and laundry.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, and the upper and lower respiratory tract. The infection control coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and this is reported to the facility manager. Recommendations to assist in infection reduction and prevention were acted upon. Infection control measures recommended by the ministry of health for the management of COVID-19 pandemic were implemented. There was no reported infection outbreak reported since the previous audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures, practices and her responsibilities.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
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## 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.