

# Whangaroa Health Services Trust

---

## Introduction

This report records the results of a Certification 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 Health and Disability Auditing New Zealand 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>	Whangaroa Health Services Trust
<b>Premises audited:</b>	Whangaroa Health Services
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 7 April 2015    End date: 8 April 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>	22

# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Whangaroa Health Services Trust – Kauri Lodge is a community owned primary health and aged care service. The service is governed by a trust board and overseen by a chief executive officer who is new to the role and an aged related care clinical manager who is also new to the role. At the time of the audit the service was being supported by a district health board (DHB) appointed temporary manager. Kauri Lodge provides care to up to 21 rest home and hospital level residents and was at full occupancy on audit day. Residents and families interviewed were very complimentary of care and support provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

This audit has identified areas for improvement around analysis of quality data for trends, staff meetings, resident meeting minutes, corrective action planning, staff reference checks, performance appraisals, infection control surveillance, activities documentation, first aid training, the admission agreement, progress notes, care plans, care plan evaluations, short term care plans and interventions.

## Consumer rights

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

The staff at Whangaroa Health Services Trust ensures that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent and advanced directives are documented. Complaints and concerns have been managed and a complaints register is maintained.

## 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.		Some standards applicable to this service partially attained and of low risk.
---	--	---

Whangaroa Health Services Trust has a quality and risk management system in the process of being re-established. This includes collection of accident and incident data, complaints, restraint and internal audits. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-

service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

Whangaroa Health Services has documented entry criteria, which is communicated to residents, family and referral agencies. Registered nurses are responsible for initial assessments, care planning, assessments and evaluations. All care plans were up to date. Resident files were integrated and demonstrated a team approach and allied health notes. Residents/family/whanau interviewed confirmed that care provided is consistent with meeting the resident's needs. The general practitioner reviews residents at least three monthly or earlier as required.

Planned activities are appropriate to the rest home and hospital residents. Community links are maintained and entertainment and outings are scheduled. Residents and family interviewed confirm satisfaction with the activities programme.

There are documented medication policies and procedures. All medicine management and administration meet legislative requirements. Medication charts sampled have photo identification and allergy status documented. The general practitioner reviews the medication chart at least three monthly.

Food service is provided on site and kitchen staff have completed food safety training. The dietitian has reviewed the menu. Residents' individual dietary needs were identified and dislikes known to staff. Alternative choices were offered, documented and reviewed on a regular basis.

## 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.

Some standards applicable to this service partially attained and of low risk.

The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. Chemicals are stored safely throughout the facility. There is a current building warrant of fitness. There is a reactive and planned maintenance programme. The internal and external building is well maintained. All bedrooms have hand basins and there are sufficient communal shower and toilet facilities available in each wing. General living areas and resident rooms are appropriately heated and ventilated. The residents have access to communal areas for entertainment, recreation and dining. There are outside paved areas, courtyard and gardens with suitable seating and shade sails. Residents are being provided with safe and hygienic cleaning and laundry services. The service is well equipped to continue operating in the event of a civil defence emergency.

## 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.

Restraint is regarded as the last resort. Any restraint/enabler use is recorded in an auditable format. The service has a restraint “champion” and approval committee. At the time of the audit there were two residents with restraints, three enablers and one resident on trial of removal of restraint. Restraint training is included in the induction programme and in-service education programme and includes staff completing a competency questionnaire.

## Infection prevention and control

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
--	--	--

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all staff as part of their orientation and also as part of the on-going in-service education programme. An infection control surveillance programme has been developed and the infection control officer reported how this will be introduced.

## 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	40	0	8	2	0	0
<b>Criteria</b>	0	89	0	10	2	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with staff (the temporary manager, the chief executive officer ( CEO), the aged related care clinical manager, three caregivers, two registered nurses and the activities officer) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Six residents (four rest home and two hospital) and three relatives (two rest home and one hospital) were interviewed and confirmed the services being provided are in line with the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need</p>	FA	<p>The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. Three caregivers and two registered nurses interviewed are familiar with the Code of Health and Disability Consumers' Rights and informed consent policy. General consent forms were signed in all five of five resident files sampled. Advance directives were appropriately signed.</p> <p>D13.1: There were five signed admission agreements sighted (link 1.3.1.4).</p> <p>D3.1.d Discussions with three family (two rest home and one hospital) identify that the service actively involves them in decisions that affect their relative's lives</p>

to make informed choices and give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the facility.
<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	A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Four complaints were received in 2014 and three to date in 2015. Systems and processes are in place to ensure that any complaint received is managed and resolved appropriately and this is confirmed in complaint documentation. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
<p>Standard 1.1.2: Consumer Rights</p>	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>relatives interviewed identified they are well-informed about the Code. Resident meetings and a resident and family survey provide the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and are available.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Church services are held weekly and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has a Maori health plan which includes cultural safety and awareness. The service has a strong kaupapa focus with 20% of residents and 90% of staff identifying as Maori. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Cultural needs and links are clearly documented in the care plan. The service has established links with local Maori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	<p>FA</p>	<p>Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process includes the signing of house rules and a service code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Registered nursing staff have completed training around professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The quality programme has been designed and recently re-established to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The CEO is responsible for coordinating the internal audit programme. Bi monthly quality meetings and residents meetings are conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the temporary manager, the CEO and the new aged residential care clinical manager. Care staff complete competencies relevant to their practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. This was confirmed on incident forms sighted. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur two monthly and the aged related care services clinical manager and CEO have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available.</p>

conducive to effective communication.		
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Whangaroa Health Services is governed by a community trust board, comprised of representatives from the local community. The service provides care for up to 20 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 20 residents in total (12 residents at rest home level and eight residents at hospital level).</p> <p>There have been significant changes in the leadership of the organisation and at the time of the audit support was being provided by a District Health Board (DHB) appointed temporary manager. The CEO is a trained social worker and has a law degree. She has been working in the health and disability field for the past 10 years. She has been in the role since February 2015. The new age related care clinical manager is a registered nurse who has been practicing in New Zealand since 2007, specialising in oncology and has held nurse coordinator roles in the DHB. He is currently undergoing a comprehensive orientation with the temporary manager as a preceptor. The CEO reports monthly to the board on a variety of management issues. The current business plan has been implemented with 2014 goals evaluated.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The age related care clinical manager provides cover during a temporary absence of the CEO.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established,</p>	PA Low	<p>The quality manual describes Whangaroa Health Services quality improvement processes. The quality management system was not implemented consistently between July and December 2014. This has been recognised and the temporary manager, new CEO and new age related care clinical manager have ensured the programme has been recommenced since January 2015. The risk management plan describes objectives, management controls and assigned responsibility. Internal audits have been completed and incidents analysed with trends identified. There has been a significant quality improvement initiative around medication errors and</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>medication management. Results of the recent accident/incident three months analysis are on the notice board for staff to see. There have been no documented staff meetings since August 2014 and quality and health and safety meeting minutes do not discuss quality data trends. Discussions with registered nurses and caregivers confirmed their involvement in the quality programme. Resident/relative meetings have been held. However minutes do not demonstrate follow through of issues raised. Data is collected on complaints, accidents, incidents and restraint use. Infection control surveillance data has not been collected since October 2014 (link 3.5.7). The internal audit schedule for 2014 has been completed. Areas of non-compliance identified at audits have not consistently been actioned for improvement and corrective action plans are not always signed as completed. The service has previously benchmarked data with other facilities in the Far North. This has recently been recommenced. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures have been re written in March 2015. There is a death/Tangihanga policy and procedure that outlines immediate action to be taken upon a resident's death. Falls prevention strategies are implemented for individual residents. Residents' are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</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>	<p>FA</p>	<p>Incident and accident data has been collected and analysed for the past three months (after a hiatus since mid-2014 when data was not analysed). Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. An appropriate section 31 notification was made to the Ministry of Health. A sample of resident related incident reports for January, February and March 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service has recently restarted benchmarking incident data with other facilities.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>PA Low</p>	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. However reference checks are not consistently documented.</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>Copies of practising certificates are kept. Five staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low among caregivers with recent changes in management roles. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. The new age related care clinical manager is completing a comprehensive orientation. Annual appraisals have not been conducted in four of five staff files sampled. A completed in-service calendar for 2014 and 2015 to date exceeded eight hours annually. The registered nurses attend external training where this is available.</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>	FA	<p>Whangaroa Health Care's has a two weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is at least one registered nurse on duty at all times. The full time age related care clinical manager is also a registered nurse. Caregivers and residents and family interviewed advised that sufficient staff are rostered on for each shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Information containing sensitive resident information are not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts have been stored in a separate folder.</p>
<p>Standard 1.3.1: Entry</p>	PA Low	<p>Prior to entry all potential residents have a needs assessment completed by the needs assessment and co-ordination service to assess suitability for entry to the service. The service has an admission policy, admission</p>

<p>To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>agreement and a resident information pack available for residents/families prior to or on entry. The admission agreement does not meet the requirements of the ARC contract. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. .</p> <p>D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p> <p>D14.1 Exclusions from the service are not included in the admission agreement.</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>	FA	<p>There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. Records are kept with the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented. The RNs communicate with family/EPOA regarding transfers and updates on the residents' condition.</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>	FA	<p>Policies and medication management has been reviewed and meet medication guidelines. RNs only administer medications and have completed education and competencies. The supplying pharmacy delivers the blister packs. One self-medicating resident has been competency assessed. The standing orders are current.</p> <p>Ten drug administration sheets sampled are correctly signed. As required medications administered have the date and time recorded on the signing sheet. The service has recently completed a significant quality improvement process around medications and this has resulted in a significant decrease in medication errors.</p> <p>Ten medication charts sampled all had photo identification and allergies noted. All medication charts are pharmacy generated and have been reviewed by the GP at least three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	FA	<p>There is a full-time qualified cook and a part-time relieving cook employed to prepare and cook all meals. The four week summer and winter menu has been reviewed by the dietitian. Resident likes, dislikes, cultural and dietary requirements are known. Residents interviewed are</p>

<p>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>complimentary about the meals and confirm alternative choices are offered for any dislikes. Specialised crockery and cutlery is available to promote independence at meal times as required. Meals are delivered in a bain marie to the rest home and hospital dining rooms. Serving temperatures are monitored. End cooked temperatures are taken weekly. Fridge (including the kitchenettes) and freezer temperatures and dishwasher temperatures are recorded daily. All foods are dated. Cleaning schedules are maintained. Staff were observed wearing personal protective clothing. The kitchen is well equipped with a good work flow.</p> <p>D19.2: Staff have been trained in safe food handling.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The admission policy describes the declined entry to services process. There have been no declined entries. Reasons for declining entry would be if the provider is unable to deliver the level of care, or the resident's behaviour may affect the other residents. Should this occur the resident/family/whānau would be referred back to the referral agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Admission documentation obtained on interview with resident/relative or advocate is comprehensive. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received is gathered by the registered nurse (RN) to develop the initial assessment and the first resident care plan.</p> <p>A range of assessment tools are available and completed on admission if applicable. The outcomes of assessments are documented in the care plans of all resident files sampled and form the basis of service delivery planning.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service</p>	<p>PA Moderate</p>	<p>An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The long term care plan is developed within three weeks. Improvements are required around long term care plans and documented evidence of resident/family/whānau input</p>

<p>delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>into care planning.</p> <p>Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs. Allied health professional involvement is linked to the resident long term care plan such as physiotherapist, diabetes nurse and district nurse.</p> <p>D16.3f: There is not consistently evidence of resident/family/whanau participation in the development of care plans.</p> <p>D16.3k: Short term care plans are available for use for changes in health status (Link 1.3.8.2).</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>PA Moderate</p>	<p>Relatives interviewed state their relatives needs are being met and they are kept informed of any changes to the resident health, GP visits, accidents/incidents, infections, and hospital appointments. The caregivers interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care. There is an improvement required around documentation and implementation of interventions to reflect the resident current health status.</p> <p>D18.3 and 4; There were adequate supplies of wound care products, blood glucose monitoring equipment, continent products and other medical equipment sighted on the day of audit. There were wound assessments completed with ongoing management and treatment plans for two grade 3 pressure areas (not facility acquired) and one minor wound. There was evidence of allied health professional input into wound care.</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>PA Low</p>	<p>The service employs an activity officer (currently in diversional therapy (DT) training) for 24 hours per week. The activity officer networks with other DTs within the region. The weekly programme is flexible to meets the recreational needs of the rest home and hospital residents. Resident participation is voluntary and the activity officer spends one on one time with residents who are unable or choose not to join in group activities. The physiotherapist co-ordinates the exercise programmes. Residents are encouraged to maintain community links and there are community visitors. The service has a company vehicle for outings, shopping trips and drives. The activity officer requires a current first aid certificate (link 1.4.7. 1).</p> <p>Resident social leisure style profiles are not completed in a timely manner. Activity plans are not evident in resident files.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	<p>PA Low</p>	<p>The long term care plan is developed within three weeks of admission and intended to be evaluated at six monthly (link 1.3.3.3) or more frequently as required. The review involves the RN, caregivers, physiotherapist (if applicable) and resident/family/whanau as appropriate.</p> <p>Two short term acute care plans had not been evaluated in a timely manner to reflect the resident's current health</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>status. The GP examines the resident at least three monthly and completes a medication review.</p> <p>ARC: D16.3c; All initial care plans are evaluated by the RN within three weeks of admission.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The age related care clinical manager and RNs are able to describe the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. The GP (interviewed) discusses specialist referrals and options for treatment with the resident/family/whanau as appropriate.</p> <p>D16.4c: The service initiates a specialist referral as required to assess a resident's need for higher level of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are stored safely throughout the facility. Safety data sheets and products sheets are readily accessible. There is appropriate protective equipment and clothing readily available for all staff.</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>Whangaroa Health Service's building holds a current warrant of fitness. Reactive and preventative maintenance occurs. Electrical test and tags have been completed. Clinical equipment has been calibrated and checked annually. Hot water temperature monitoring has been completed monthly and within the acceptable range. .</p> <p>Hallways are spacious enough to allow residents to mobilise with the aid of walking frames safely and other mobility aids. There is adequate space and access in communal areas. There is safe access to outdoor areas, courtyard and gardens with seating and shade sails.</p> <p>ARC D15.3; There is adequate equipment available for rest home and hospital level of care.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	<p>FA</p>	<p>All bedrooms have hand basins. One two bedded room has an ensuite. There are adequate numbers of communal toilets and showers in each wing. Residents interviewed confirmed that staff provide the resident with privacy when attending to personal hygiene cares</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and</p>	<p>FA</p>	<p>There are three rooms with two beds. These rooms are spacious and have privacy curtains. All other rooms are single. Bedrooms viewed on the day of audit were personalised.</p> <p>Residents interviewed confirm their bedrooms are of adequate size and they can personalise them as they like.</p>

setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The rest home and hospital wings have separate kitchenette and open plan dining and lounge areas. Activities occur in both lounges. Residents are able to access communal areas both with and without assistance.</p> <p>D15.3d; Seating and space is arranged to allow both individual and group activities to occur.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There is a laundry manual and cleaning manual that describes laundry and cleaning processes. There is an external laundry with defined clean and dirty flow. All sheets are laundered off-site. The towels and personal clothing is laundered on-site. There are designated cleaning and laundry staff. Staff were observed to be wearing appropriate protective clothing. The cleaners trolley was well equipped and locked in a designated cleaners room when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	PA Low	<p>An approved evacuation plan has been signed off by the New Zealand Fire Services. A fire drill takes place every six months. Emergency flip charts are available in staff areas. The service is well prepared in the event of a disaster with an independent power supply (back-up generator) and its own water supply that is treated and tested daily. There is an alternative cooking source (barbeque) and sufficient food supplies for at least three days. Calls bells are located in all bedrooms, toilets and bathrooms.</p> <p>Staff do not have first aid certificates.</p> <p>The facility is secure after hours with doorbell access.</p>

situations.		
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	All bedrooms and communal areas have external windows allowing adequate ventilation and natural light into the rooms. The facility has appropriate heating.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	Whangaroa Health Services has an established infection control (IC) programme that has been in hiatus since the previous infection control nurse champion resigned in October 2014. A new infection control nurse champion was appointed immediately before the audit. The documented infection control programme is appropriate for the size, complexity and degree of risk associated with the service and is to be linked into the incident reporting system. The IC team includes all involved in the quality and health and safety meetings where infection control is a standing agenda item. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources</p>	FA	There are adequate resources to implement the infection control programme at Whangaroa Health Services. The infection control (IC) nurse champion has recently completed the Ministry of Health on line infection control training. The infection control team is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.

<p>to implement the infection control programme and meet the needs of the organisation.</p>		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies have been reviewed and rewritten in March 2015.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control nurse champion with support from the age related care clinical manager. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection. Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014.</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>PA Low</p>	<p>Infection surveillance is described in infection monitoring policy. A registered nurse is the designated infection control nurse champion. Infection control surveillance has not occurred since October 2014 when the previous infection control coordinator resigned. There is a monthly infection data sheet for all infections based on signs and symptoms of infection. Individual resident infection forms have been developed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections will be entered on to a monthly facility infection summary and staff will be informed as reported by the newly appointed infection control officer. The service has recently re-established benchmarking with other similar facilities in the far north. There have been no recent outbreaks.</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>The restraint minimisation and safe practice programme has been reviewed and aligns with the restraint minimisation and safe practice HDSS standards. Restraint is only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Enablers are voluntary and the least restrictive option. Three enablers (bedrails) were in use. The use of enablers is linked to the long term care plans.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service</p>	<p>FA</p>	<p>A registered nurse is the restraint “champion” and has a job description that defines the responsibilities of the role. There is an approval group that meets annually. The approved restraints are documented in the restraint policy. There is currently one restraint (chair brief) on trial of removal. There are two residents with restraints (bedrails).</p> <p>Restraint and consent is in consultation/partnership with the resident (as appropriate), family or whanau, the restraint “champion” and GP. The use of restraint and associated risks are linked to the care plan. Restraint education is provided on orientation and all staff have completed mandatory training March 2015. Staff have completed restraint competency assessments. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated at least three monthly or earlier if required.</p>

providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Restraint assessments are undertaken by the restraint “champion” or registered nurse in partnership with the resident and their family/whanau. Restraint assessments are based on information in the initial care assessment, long term care plan, resident/family discussions, RN and care staff observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments.</p> <p>Two files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The restraint “champion” is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint. Restraint authorisation is in consultation with the consumer (as appropriate), family/whanau and the GP.</p> <p>Restraint use is reviewed three monthly. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring requirements are documented and the use of restraint evaluated regularly. There is a restraint register which provides an auditable record.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Written evaluations are completed at least three monthly or earlier if required as part of the three monthly medical review. Effective de-escalation strategies are reviewed by the restraint “champion” and approval committee.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraint usage is monitored regularly by the restraint “champion” and approval committee. Enabler and restraint use is discussed quarterly at the quality/health and safety meeting. An internal restraint audit is completed annually with 100% compliance.</p>

## 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	The service has recently reintroduced the quality programme. Accidents and incidents are analysed for trends for January, February and March 2015. This was completed immediately before the audit so the outcomes have not been discussed in quality or staff meetings. The trend analysis data is on the noticeboard for staff to read.	(i) There have been no minuted staff meetings since August 2014. (ii) Bimonthly quality and health and safety meeting minutes to not document discussion around quality data trends.	(i) Ensure regular staff meetings occur and these are minuted. (ii) Ensure that trend analysis outcomes are discussed in quality and health and safety meetings.  90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring	PA Low	Internal audits are conducted according to the audit schedule. For 40% of audits where shortfalls were identified a corrective action	(i) Corrective action plans are not consistently developed when service shortfalls are identified through internal audits. Plans that are developed are not consistently signed off as implemented. (ii)	(i) Ensure corrective action plans are developed, implemented and signed off when

improvement in order to meet the specified Standard or requirements is developed and implemented.		plan was developed. There are bi monthly resident meetings and these are minuted.	Resident meeting minutes do not demonstrate that issues raised are addressed and outcomes reported back.	service shortfalls are identified. (ii) Ensure resident meeting minutes document follow through on issues raised.  90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Staff training is generally completed with compliance days which are repeated more than once to ensure attendance. Two compliance days in October 2013 covered infection control, health and safety, emergency plan, fire safety, CPR, advocacy and code of rights. The most recent compliance day in March 2014 included infection control, health and safety, cultural safety and CPR. There has been significant recent training around medication management. Training booked for 2015 includes falls prevention, wound management and chemical safety.	Five of five staff files sampled do not have a current performance appraisal.	Ensure all staff have an annual performance appraisal.  180 days
Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly	PA Low	Residents (two rest home and four hospital) and family/whanau (two rest home and one hospital) confirmed on interview they had received all relevant information on admission. The information pack contains an information book, the Code and brochure of the service,	The admission agreement does not meet the requirements of the ARC contract.	Ensure the admission agreement meets the requirements of the ARC contract.  90 days

communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.		and an advocacy brochure. The previous admission agreement met the contract requirements. This was changed by the last CSM and no longer meets requirements. The service has an electronic admission agreement available that does meet requirements.		
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Initial assessments are completed within 24 hours of admission. The long term care and support plan is developed within three weeks in five of five resident files sampled. All resident care plans sampled had been changed to a new care plan format dated April 2015.	Long term care plans have not been reviewed six monthly for one hospital and two rest home residents. One hospital resident and one rest home resident had not been at the service six months.	Ensure care plans are reviewed six monthly.  180 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Caregivers interviewed were able to describe a verbal and written handover. Progress notes are kept the integrated file. Rest home resident progress notes are maintained at least weekly.	Progress notes viewed in resident files did not always have the time of entry recorded. Progress notes in the two hospital resident files had not been written daily as per protocol.	Ensure progress notes document the time of entry and are written daily for hospital residents.  90 days
Criterion 1.3.5.2	PA	Residents/families interviewed state they are involved in care	1) There is no documented evidence of resident/family/whanau participation in the	1) Ensure there is documented evidence of

<p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>Moderate</p>	<p>planning and receive copies of the care plan. All resident files had recently completed care plans in the new format that describes resident goals, objectives and support required to meet the resident goals. Short term care plans were in use for one rest home resident with short term needs.</p>	<p>development of care plans for three rest home and one hospital resident. 2) Not all long term care plans reflected the resident's current needs, supports and interventions as follows: a) there is no diabetes management plan for two residents (one rest home and one hospital) who are insulin dependent. b) The behaviour management plan has not been updated to reflect altered behaviours for one rest home resident. c) Management of neck pain as per medical notes is not documented in the long term care plan for one rest home resident. d) Mental health disorder has not been included in the long term care plan as per specialist letter for one hospital resident. 3) Short term care plans have not been developed for three residents (two rest home and one hospital) with short term needs.</p>	<p>resident/relative/whanau participation in care planning. 2) Ensure care plans describe the supports and interventions required to meet resident goals. 3) Ensure short term care plans are implemented for short term needs.</p> <p>90 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the registered nurses initiate a review and if required, GP or nurse specialist consultation.</p>	<p>There is no documented evidence to reflect the resident's current health status as follows: a) no fluid balance record to ensure a 2 litre intake as per specialist letter. b) no pain assessment or documentation for resident who identifies pain, c) weekly weigh has not been completed and there are no records of 1.5 litre intake as per care plan d) there are no documented interventions for resident with altered behaviours as per progress notes and medical notes.</p>	<p>Ensure documented and implemented interventions reflect the resident's current health status.</p> <p>60 days</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources,</p>	<p>PA Low</p>	<p>Resident social leisure style profiles are available for resident/family/whanau to complete in admission. The resident's spiritual, cultural and brief statement on activities is included in the new format long</p>	<p>The resident social leisure profile has not been completed for one rest home resident. There are no specific/individualised activity plans in five of five resident files reviewed. There is no evidence of six monthly activity reviews at the same time as the care plan reviews.</p>	<p>Ensure resident social leisure style profiles are completed on admission. Ensure residents have an individualised activity plan that is reviewed at</p>

and interests) that are meaningful to the consumer.		term care plan. Activity attendance sheets are maintained.		the same time as the care plan.  180 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Short term care plans are utilised for resident short term needs and evaluated or resolved with ongoing problems added to the long term care pan.	Two short term care plans dated October 2014 and February 2015 had not been reviewed.	Ensure short term care plans are reviewed in a timely manner.  60 days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Low	The orientation programme includes fire, emergency and security training. Education is ongoing.	Staff do not have current first aid certificates.	Ensure there is one person trained in first aid on duty at all times.  90 days
Criterion 3.5.7	PA Low	The infection control coordinator	There has been no infection control surveillance	Implement the

<p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>was appointed four days prior to the audit. A new programme and associated documents have been developed and the infection control officer was able to describe how these will be used.</p>	<p>implemented since the previous infection control nurse resigned in October 2014.</p>	<p>documented infection surveillance programme as planned.</p> <p>90 days</p>
---	--	--	---	---

## 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, 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
--------------------

End of the report.