

Kohatu Resthome Limited

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 Audit (NZ) 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:

Legal entity: Kohatu Resthome Limited

Premises audited: Kohatu Resthome

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 15 September 2015 End date: 16 September 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 19

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

Kohatu Rest Home provides rest home level care for up to 24 residents. The service is managed by a facility manager who is a registered nurse. The residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the district health board. The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

There are 10 areas identified that require improvement relating to: aspects of quality and risk; recruitment of staff; staff training; resident documentation; medicine management; hot water temperatures and maintenance of the driveway.

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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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are all accessible. This information is brought to the attention of residents (where able), and their families on admission to the facility. Residents and family members confirmed their rights are being met, staff are respectful of their needs and communication is appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Written consent is gained as required. Residents and family members are provided with Information prior to giving informed consent and time is provided if any discussions and explanation are required.

Staff receive ongoing training on residents' rights and how these should be implemented on a daily basis. Services are provided that respect the independence, personal privacy, individual needs and dignity of residents. All aspects of service delivery are consistent with upholding and respecting residents' rights.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination or abuse and neglect, with these policies well understood by staff.

The facility manager is responsible for the management of complaints 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 medium or high risk and/or unattained and of low risk.
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Kohatu Rest Home Limited is the governing body and is responsible for the services provided at this facility. There is a business plan and quality and risk management systems for Kohatu Rest Home and documented scope, direction, goals, values, and mission statement were reviewed. Systems are in place for monitoring the services provided including regular monthly reporting by the facility manager to the owner.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse with aged care experience and they have been in this position since 2008. The facility manager is also responsible for the oversight of the clinical services in the facility.

There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms, and meeting minutes evidence corrective action plans are not consistently developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff meetings are held and there is reporting on various clinical indicators, quality and risk issues and discussion of any trends identified. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resource management, which are implemented. Staff files evidence no reference checking prior to employment. An in-service education programme is provided for staff at least monthly. Training around wound management and the safe use of chemicals has not been provided. Staff are also encouraged to complete the New Zealand Qualifications Authority Unit Standards.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The facility manager is on call after hours.

Resident information is entered into a register in an accurate and timely manner. The privacy of resident information is maintained. The name and designation of staff making entries into residents' clinical records is legible.

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>		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation works with the Needs Assessment Co-ordination Service to ensure access to the service is efficient with all relevant information available, whenever there is a vacancy.

Residents' needs are assessed on admission by the registered nurse. Residents' files sighted provide evidence that not all needs, goals and outcomes are identified. Care plans are reviewed on a regular basis. Residents and families interviewed report being well informed and involved, and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice; however practices sighted were not always consistent with these documents.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

Safe and appropriate environment

<p>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.</p>		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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A current building warrant of fitness is displayed. However, hot water temperatures at some resident outlets are above 45 degrees Celsius. A preventative and reactive maintenance programme includes equipment and electrical checks.

All residents' bedrooms provide single accommodation. Residents' rooms have adequate personal space provided. Lounges, dining area and alcoves are available. External areas are available for sitting and shading is provided. The sealed driveway along the front of the facility is uneven and several potholes have developed making it unsafe for residents to walk on.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site and cleaning and laundry systems, including appropriate monitoring systems, are in place to evaluate the effectiveness of these services.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		Standards applicable to this service fully attained.
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The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard and identifies the use of enablers is voluntary and the least restrictive option to meet resident need. Policy identifies the services responsibility for the non-use of restraints.

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 service provides an environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control nurse reporting directly to the owner.

There is an infection prevention and control programme which is reviewed annually. An infection control nurse is responsible for this programme, including education and surveillance.

Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	39	0	1	5	0	0
Criteria	0	83	0	1	9	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	New staff receive education related to the Health and Disability Commissioner's Code of Health and Disability Services Consumer's Rights (the Code) as part of their orientation programme. On-going education on the Code is also provided to all staff. Staff demonstrated a good understanding of the requirements of the Code, outlining how these are then incorporated into their everyday practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The informed consent policy guides service providers in relation to informed consent. Evidence was sighted in residents' files of formal, documented consent relating to general consent. Consent is also obtained on an as-required basis, such as for the recent 'flu' vaccinations. There was evidence of advance directives signed by the resident. Residents confirmed they are supported to make informed choices, and their consent is obtained and respected. Family members also reported they are kept informed about what is happening with their relative and consulted when treatment changes are being considered.

<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	<p>Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. This was confirmed in staff training records. Staff demonstrate their understanding of the advocacy service, with contact details for the service readily available.</p> <p>Residents are provided with information on the advocacy service as part of the admission process. Residents and family members confirmed their awareness of the service and how to access this, although all stated they would feel comfortable about approaching the facility manager should they have any concerns.</p>
<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	<p>Residents are encouraged to maintain their community interests and networks, and to visit with their families. The service's activities programme includes regular outings in the facility's mobility vans and participation in community events. Community groups, different church denominations and entertainers also visit the facility on a regular basis.</p> <p>The service welcomes visitors, and has unrestricted visiting hours. Family members advised they feel very welcome when they come to visit. Residents reported they are supported by staff to access health care services outside of the facility.</p>
<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 facility manager is responsible for complaints and there are appropriate systems in place to manage the complaints process. The complaints register is current and includes three complaints for 2015 and these were managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes.</p> <p>The complaints process is readily accessible and/or displayed. Review of the staff meeting minutes provide evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via the staff meetings.</p> <p>There has been one investigation by the DHB since the last audit relating to the care of a resident. Documentation reviewed evidenced this investigation is now closed.</p> <p>There have been no investigations by the Ministry of Health, Health and Disability Commissioner, Accident Compensation Corporation (ACC), Police or the Coroner since</p>

		the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	<p>During the admission process, new residents and their family are given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service. The facility manager advised this information is discussed with them during the admission process and any questions they may have are answered. Staff are also available to discuss the Code and/or the advocacy service with the individual resident and/or their family at any other time if they require additional information or clarification. Posters of the Code are displayed at the facility.</p> <p>Residents and family members are familiar with the Code and the advocacy service. Although none of those interviewed had concerns about any aspect of the services being provided, all stated they would feel comfortable raising issues with the facility manager.</p>
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>Residents are addressed by their preferred names. Each resident has a private room, which they are encouraged and supported to personalise. Staff were observed knocking on closed doors before entering, and maintaining the privacy and dignity of residents during personal cares. During interviews, residents and family members confirmed they are treated respectfully and that the individual needs and preferences of residents is acknowledged and accommodated. The resident and family satisfaction survey collated August 2015 indicated high resident satisfaction concerning their rights being respected.</p> <p>The residents' records include documentation relating to individual cultural, religious and social needs, values and beliefs that had then been incorporated into their individual care plan. Evidence was sighted that these plans had been developed in conjunction with the resident and/or their family.</p> <p>The service's policy relating to abuse and neglect is understood by staff. Staff gave examples of what would constitute abuse and neglect and the actions they would take if they suspected this. Staff have received education related to abuse and neglect. Staff employment contracts contain information relating to expected standards of behaviour, and the disciplinary actions that would ensue should those standards not be met.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs	FA	The service has a 'Maori Health Plan' that guides staff relating to meeting the needs of residents who identify as Maori. The facility manager also detailed the networks that are

<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>established locally if additional support is required to support any residents who identify as Maori. The care plans for residents who identify as Maori have their cultural needs documented and met. Interview of residents confirmed this. Four staff members identify as Maori and one speaks Te Reo and is responsible for blessing the rooms at Kohatu.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The individual preferences, values and beliefs of residents are included in the care plans reviewed. The plans include detailed interventions to ensure resident's individual requirements are accommodated. Residents and family members advised they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs are respected.</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>Residents and family members stated that residents are free from any type of discrimination or exploitation. The facility manager advised that the orientation for new staff includes education related to all forms of discrimination and exploitation. Information on this topic is also included in each staff member's employment contract. The staff orientation programme includes information relating to discrimination and there is regular training for all staff on the topic. Staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has established professional networks to help ensure residents receive services of an appropriate standard, including specialist services at the local district health board (DHB). Clinical policies, which are current and reflect best practice, are available to guide staff in care delivery. External educators provide education sessions and staff are encouraged to attend these.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>A review of accident/incident forms showed timely and open communication with residents/family members. Communication with family members is recorded in the contact sheets and progress notes. Family members expressed a high level of satisfaction with how well they are kept informed about any change to the resident's condition and their involvement in resident care planning. Resident meetings are held monthly and minutes</p>

		were reviewed. The facility manager advised that interpreter services are able to be accessed from the local DHB, if required. This information is also provided to residents/families as part of the information pack provided as part of the admission process.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Kohatu Rest Home Limited is responsible for the services provided at Kohatu Rest Home. A business plan and a risk management plan were reviewed that included goals, purpose, objectives, mission statement and values. The facility is managed by a facility manager who is an experienced registered nurse with extensive aged care experience and has been in this position since November 2008. There was evidence in the facility manager's file of appropriate ongoing education. The service's philosophy is in an understandable form and is available to residents and their family/representative or other services involved in referring residents to the service. On the first day of this audit there were 19 residents assessed as rest home level care. Contracts with the DHB include 'Long term Support – Chronic Health Conditions', 'Residential Respite Services', and Aged related Residential Care'.
Standard 1.2.2: Service Management 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.	FA	There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager be absent. The activities coordinator / administrator is responsible for the day-to-day management of the facility during the facility manager's absence with support from a registered nurse from the local GP's practice for clinical overview. The owner is also available if needed. Services provided meet the specific needs of the resident groups within the facility.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	A quality and risk management plan was reviewed and is used to guide the quality programme and includes goals and objectives. The resident and relative satisfaction survey collated in August 2015 indicated that residents and families were satisfied with the services provided. Completed audits for 2014 and 2015, clinical indicators and quality improvement data was recorded on various registers and forms. Review of the quality improvement data

		<p>provided evidence the data is being collected, collated, and analysed to identify trends. Corrective actions plans are not consistently developed and implemented following audits, surveys and staff and resident meetings. Who is responsible for the corrective action, the timeframe for completion and whether the action has been reviewed was not documented.</p> <p>The facility manager provides monthly reports to the owner. Monthly staff meetings include quality, restraint, infection control, health and safety and minutes were reviewed. There was documented evidence of reporting on various clinical indicators and quality and risk issues in these meetings. Staff reported that copies of meeting minutes and graphs are available for them to review in the staff areas. Observations during the audit confirmed this.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice and reference legislative requirements. Policies and procedures are reviewed by the facility manager and are current. Staff confirmed that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for service delivery.</p> <p>A health and safety manual is available. There is a hazard reporting system available as well as a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual and clinical risks.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the facility manager and signed off when completed. Corrective action plans to address areas requiring improvement are documented on accident/incident forms. The facility manager undertakes assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>Staff confirmed that they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they are completing accident/incident forms for adverse events. Policy and procedures comply with essential notification reporting for example: health and safety; human resources; infection control.</p> <p>The facility manager stated they have reported two essential notifications to Ministry of Health since the previous audit. Documentation reviewed confirmed this.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, police vetting and completed orientations. Not all staff files reviewed had no evidence of reference checking prior to employment. Current copies of annual practising certificates were reviewed for the facility manager and contractors that require them to practice.</p> <p>The facility manager is responsible for the in-service education programme. The education planners for 2014 and 2015 were reviewed and education is provided at least monthly. Individual staff attendance records and attendance records for each education session were reviewed and evidence ongoing education is provided. However, there was no evidence that ongoing training on wound management and the safe use of chemicals has occurred. The facility manager confirmed this.</p> <p>Competency assessment questionnaires are current for medication management and restraint. The facility manager has the required interRAI assessments training and competencies.</p> <p>Care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers.</p> <p>An appraisal schedule is in place and current staff appraisals were in the staff files.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.</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>There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. The facility manager is full time and is on call after hours. The minimum number of care staff on duty is during the night and consists of one caregiver.</p> <p>There is at least one staff member on duty with a current first aid certificate. Care staff reported there are adequate staff available and that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate</p>

		care.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	<p>Resident related information is kept in hard-copy. These files are maintained securely. Archived material is also kept securely and is easily retrievable.</p> <p>All components of the residents' records reviewed include the resident's unique identifier. The clinical records reviewed were organised and integrated, including information such as medical notes, assessment information and reports from other health professionals.</p> <p>Resident progress notes are completed every shift. Entries made by the service providers in the progress notes clearly identify the name of the person making the entry.</p>
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	<p>When the need for service had been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner.</p> <p>Information about the service is accessible and includes details of the services provided, its location and hours, how the service is accessed and identifies the process if a resident requires a change in the care provided.</p> <p>Files reviewed contained pre entry screening processes, ensuring compliance with entry criteria. Signed admission agreements meet contractual requirements.</p>
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	<p>The medication management policy is comprehensive and identifies all aspects of the medicine management. However a safe system for medicine management that complies with policy and safe practice was not observed on the day of audit. This was immediately attended to, and for this reason the risk level was lowered from high to moderate.</p> <p>Controlled drugs are stored in separate locked cupboards. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences</p>

		<p>weekly and six monthly stock checks and accurate records.</p> <p>The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP reviews are recorded on the medicine chart.</p> <p>There were no residents' who self-administered their medicines on the days of audit, however appropriate processes are in place to ensure this is managed in a safe manner if required.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are not used. Any pro re nata (PRN) (as required) medication administered require authorisation on the resident's medication chart. PRN medication requests include indications for use.</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>	FA	<p>The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu. Any occasional deviations from the menu are evidenced as documented in a notebook.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p> <p>The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule was sighted as was verification of compliance.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate</p>

		assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	An interview with the facility manager verified a process exists for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	<p>On admission, residents have their needs identified through a variety of information sources that include: the Needs Assessment and Service Coordination (NASC) agency, other service providers involved with the resident; the resident; family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident's bedroom with the resident and/or family/whanau present if requested.</p> <p>Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. A medical assessment is undertaken within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. A multidisciplinary assessment is undertaken yearly.</p>
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	<p>The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and describes the required support the resident needs to meet their goals and desired outcomes, however in some files reviewed the requirements related to each resident's medical and nursing needs is not included in the care plan, and this needs to be addressed.</p> <p>Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written.</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>Interviews with care staff verified the provision of care provided to residents was consistent with residents' needs and desired outcomes (refer 1.3.5.2)</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and meet 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>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities provided are diverse and include regular outings, and involve community groups. Activities reflect residents' goals and residents' ordinary patterns of life. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.</p> <p>A residents' meeting is held monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Moderate	<p>Resident care is evaluated daily and reported in the progress notes. If any change is noted it is reported to the RN.</p> <p>Formal care plan evaluations, following the reassessment of the resident occurs every six months and are carried out by the RN. However evaluations sighted, do not document the level of response to an intervention, and this requires attention.</p> <p>A short term care plan is initiated for short term concerns, such as infections. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews, verified residents and family/whanau are included and informed of all changes.</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</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the</p>

is appropriately facilitated, or provided to meet consumer choice/needs.		family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency via ambulance if the circumstances dictate.
<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>	FA	<p>Documented processes are in place for the management of waste and hazardous substances including specific labelling requirements. Material safety data sheets provided by the chemical representative are available and accessible for staff. Ongoing education on chemical safety was not provided as part of the staff in-service education programme (refer to criterion 1.2.7.5). Staff have received training on waste and infectious substances.</p> <p>Observations provided evidence that hazardous substances were correctly labelled, the containers were appropriate for the contents including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled were provided and being used by staff. For example, gloves, aprons and visors were sighted.</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>	PA Moderate	<p>A current building warrant of fitness is displayed that expires on the 7 March 2016. Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Documentation, interviews and observation confirmed this. The testing and tagging of equipment and calibration of bio medical equipment is current.</p> <p>Hot water temperatures at some resident outlets have been consistently above 45 degrees Celsius over several months.</p> <p>External areas are available that are safely maintained and appropriate to the resident group and setting, apart from the sealed driveway outside the front entrance where there are potholes and the surface is uneven.</p> <p>Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use any equipment.</p> <p>Residents confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents</p>

		are able to move freely around the facility and that the accommodation meets their needs.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	<p>Three bedrooms have an ensuite consisting of a wash hand basin and a toilet. All other rooms have a wash hand basin. There are an adequate number of accessible communal showers, toilets and hand basins for residents. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned.</p> <p>Communal toilets and showers have a system that indicates if it they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</p>
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All bedrooms provide single accommodation. All rooms were personalised to varying degrees. Bedrooms are large enough to provide personal space for residents, and allow staff and equipment to move around safely.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Adequate access is provided to the lounges and dining areas. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	<p>Cleaning and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals/poisons.</p> <p>All linen is washed on site and there is a dirty to clean flow provided in the laundry. Care staff are responsible for the management of laundry. Staff described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. Care staff described the cleaning processes.</p> <p>Observations provided evidence that safe and secure storage areas are available and staff</p>

		<p>have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; and appropriate facilities exist for the disposal of soiled water/waste. Convenient hand washing facilities are available, and hygiene standards are maintained in storage areas.</p> <p>Residents and families stated they are satisfied with the cleaning and laundry service. The resident and relative satisfaction survey confirmed this.</p>
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	<p>Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification are available. Policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors are available.</p> <p>A New Zealand Fire Service letter approving the fire evacuation scheme dated 31 March 1995 was sighted. The last trial evacuation was held on the 10 September 2015.</p> <p>Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.</p> <p>Information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones.</p> <p>There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident groups and setting. Call bells are accessible/within reach, and are available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural	FA	<p>Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe</p>

<p>light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>and comfortable temperature. A covered area outside the building is available for both residents and staff who smoke.</p>
<p>Standard 3.1: Infection control management 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	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme.</p> <p>The infection control programme, reviewed annually, establishes, maintains and monitors procedures covering infection control practices.</p> <p>The infection control practices are guided by the infection control manual, with assistance from the DHB infection control nurse where needed.</p> <p>It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted at audit. Reporting lines are clearly defined.</p>
<p>Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control nurse (ICN) is the facility manager and is responsible for implementing the infection control programme. They reports directly to the owner. A position description is included in the infection control (IC) programme.</p> <p>The ICN and observation verified there are enough human, physical and information resources to implement the infection control programme. Training records sighted and interview verified the ICN attends regular ongoing training.</p>
<p>Standard 3.3: Policies and procedures 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>	FA	<p>The infection control programme includes policies and procedures which are current, reflect best practice and are signed off by ICN.</p> <p>Staff interviewed verifies knowledge of infection control policies. Staff are observed to be compliant with generalised infection control practices.</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>Interviews, observation and documentation verified staff have received education in infection control and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation.</p> <p>Resident education occurs in a manner that recognises and meets the residents' and the families' communication style, as verified by resident and family interviews.</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>In line with the infection prevention and control policy and procedures, monthly surveillance of all infections is occurring. These are collated each month and analysed to identify any significant trends or possible causative factors. Incidents of infections are presented at the staff/quality meeting every month. Any immediate action required is presented to staff at hand over. Any ongoing actions required are presented to staff at staff meetings and any necessary corrective actions discussed, as evidenced by meeting records, infection control records and staff interviews. A comparison of previous infection incidents is used to analyse the effectiveness of the programme.</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 policy reflects the requirements of the restraint minimisation and safe practice standard. It states that the service refrains from the use of restraints. The service had no restraints or enablers in use at the time of audit as evidenced by observation, documentation and interviews. The services policy was understood by all care staff interviewed and annual education related to restraint is a mandatory attendance topic. The restraint coordinator is the facility manager and the restraint committee meets every six months as evidenced by meeting minutes.</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 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	Corrective action plans to address areas requiring improvement are documented on accident/incident forms. Corrective action plans are not consistently developed and implemented following deficits identified from audits, resident and relative surveys, staff and resident meetings. Where corrective actions are developed, there is no evidence of who is responsible for the action, timeframes for completion and whether the action has been reviewed.	Corrective action plans are not consistently developed and implemented following audits, surveys and staff and resident meetings. There is no evidence of who is responsible, the timeframe for completion and review.	Provide evidence that corrective action plans are consistently developed and implemented following any deficit identified. Document who is responsible for the action, timeframes for completion of the action and review following completion of the corrective action. 90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the	PA Low	Job descriptions outline accountability, responsibilities and authority, and the skills and knowledge required for each position. Staff files have employment agreements, code of conduct, police vetting and	Four of the five staff files reviewed do not have documented reference checks	Provide evidence that all potential employees have reference checks completed prior to

needs of consumers.		completed orientations. Four of the five staff files reviewed had no evidence of reference checks prior to employment.	completed.	employment. 180 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 Moderate	Ongoing education is provided for staff apart from ongoing training in wound management and the safe use of chemicals. The facility manager confirmed this. The facility manager contacted the wound specialist nurse from the DHB while the auditors were on site and arranged a session for staff on wound management. The education planners for 2014 and 2015 were reviewed and education is provided at least monthly. Attendance records for each education session were reviewed and evidenced	There has been no ongoing education on wound management and the safe use of chemicals.	Provide evidence that staff have received ongoing education on wound management and the safe use of chemicals. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	On the day of audit it was observed there were discrepancies between what medication was prescribed and what was administered or in the medication packs. Two residents had medications prescribed, that were not in the medication packs. One resident had an inhaler administered at lunchtime, when it was prescribed to be given at breakfast, dinner and bedtime. It was being administered at breakfast, lunch and tea at the resident's request. One resident had pain relief prescribed prn, and it was packed and administered with regular medication. Interview verified medication packs are not checked against prescription when they are received from the pharmacy. On the day of audit to address these findings, medication charts were reviewed by the residents' doctors to record the accurate prescription and taken	Medications are not being administered as prescribed or as per guidelines.	Provide evidence a safe medicines management system is operating. 90 days

		to the pharmacy to get the correct medications dispensed.		
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	<p>All staff who administer medications have been assessed as competent to do so, and these are up to date. However, the medication errors described had not been detected prior to audit, and reported to the RN.</p> <p>The inhaler was consistently being administered at a time not prescribed. This finding was immediately addressed by the facility manager. An urgent education session was presented that was attended by all medication competent staff. Following the session all competencies were reviewed.</p> <p>A review of medication management processes by the auditor following an urgent education session, evidenced staffs awareness of policy.</p>	<p>Staff had current medication competencies, however observation by the audit team evidenced practices did not reflect the competency standard.</p>	<p>To provide evidence that staff responsible for medicine management are competent.</p> <p>90 days</p>
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	<p>A resident's warfarin is prescribed to be given regularly at 3mg per day; however the dose being administered is as per blood test result.</p> <p>This was attended to on the day of audit with the doctor recharting the correct prescription request. For this reason it is now rated a moderate risk.</p>	<p>Medicine management information is not recorded to a level of detail to comply with legislation and guidelines.</p>	<p>Provide evidence medicine information is monitored to ensure it is recorded to a level of detail to comply with legislation and guidelines and be administered correctly.</p> <p>90 days</p>
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired	PA Moderate	Three residents with specific medical conditions requiring detailed nursing management have no documented plan detailing the interventions required, however there is some evidence of monitoring and management strategies being provided in the	Care plans do not always describe the support required to achieve the desired outcome.	Provide evidence that residents' care plans describe the required support the resident needs to achieve the desired

outcomes identified by the ongoing assessment process.		residents' progress notes. A resident on a medication that predisposes the resident to some risks has no reference to this in the care plan, or the risk factors care staff need to be alerted to.		outcome. 90 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 Moderate	Files reviewed evidenced evaluations documented as 'no change' and do not indicate the degree of response/progress to meeting a desired outcome.	Care plans are not evaluated in a comprehensive manner.	Provide evidence care plans are documented in a comprehensive manner to indicate the degree of progress towards the desired outcome. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Documentation, interviews and observation confirmed this. The testing and tagging of equipment and calibration of bio medical equipment is current. The monitoring form showed hot water has been delivered to a number of resident outlets over several months which is above 45 degrees Celsius. The owner contacted a plumber while the auditors were on site and the temperature was turned down. Subsequent monitoring showed the hot water temperature had dropped below 45 degrees Celsius.	Hot water temperatures delivered to some resident outlets is above the required temperature of 45 degrees Celsius or below.	Provide evidence that hot water temperatures monitored at resident outlets are consistently 45 degrees Celsius or below. 90 days

<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>PA Moderate</p>	<p>Apart from potholes in the sealed driveway in the drive outside the main entrance. external areas are available that are safely maintained and appropriate for resident use. The owner reported they have received a quote to replace the section of seal and that this is expected to completed in the next few months.</p>	<p>Potholes have developed in the sealed driveway in front of the main entrance and the rest of the surface is uneven where other potholes have been repaired.</p>	<p>Provide evidence that the section of seal outside the front entrance has been replaced so that the surface is safe for residents walk on. 90 days</p>
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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 audit.

No data to display

End of the report.