

# Tui House Limited

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Tui House Limited
<b>Premises audited:</b>	Tui House
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 12 December 2016    End date: 12 December 2016
<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>	62

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
Yellow	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
Red	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

Tui House is an aged care service and is one of three privately owned and operated by the same family whose company name is Heritage Healthcare Limited. Tui House can provide care for up to 74 rest home and hospital care residents. There are 43 beds which can be used as dual purpose beds for either rest home or hospital level care residents.

The owner/general manager (GM) is a registered nurse who is actively involved in the business.

This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the provider's contract with the district health board (DHB). The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family/whanau, management, staff and the general practitioner (GP).

Specific DHB followup requests were reviewed and have all been met by the service.

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

## 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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Services are provided in a manner that is respectful of residents' rights and acknowledges cultural and individual values and beliefs. Interpreter services are used when required. The sharing of information with residents and family/whānau is documented.

The service has a complaints management system in place which meets the standard and legislative requirements. At the time of audit there was one outstanding Health and Disability Commission complaint.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Tui House strategic planning is undertaken by the GM with input from the members of senior management. The annual business plan and strategic goals reflect organisational planning outcomes. The facility manager is supported by the GM, registered nursing staff including a clinical nurse leader, and a facility coordinator. The facility manager is suitably experienced to run the service and has been in the current role for over four years.

There is a documented quality and risk management system that supports the provision of clinical care. Policies are reviewed by the management team as required. Policies reflect current good practice and meet legislative requirements.

Quality and risk performance outcomes are reported and monitored by the organisation's senior management team. Corrective action planning is implemented to manage any areas of concern or deficits. Review of service delivery includes incidents/accidents, infections, complaints and trended data reports from the internal audit programme.

The adverse event reporting system identifies that staff comply with policy and staff document and report all adverse, unplanned or untoward events.

Human resources practices are implemented. The staffing skill mix is appropriate for the level of care and services provided. Every shift is covered by a registered nurse and at least one staff member who has a current first aid certificate.

As confirmed during resident and family/whānau interviews, the services provided meet residents' needs.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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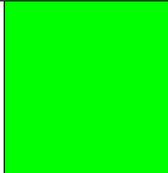
Service delivery meets the needs of the residents at hospital and rest home level of care, including the specific needs of the younger people. The initial and ongoing assessments, development of the care plans, reviews and evaluations are conducted in time frames that meet contractual requirements, or sooner when there is a change in the resident's needs. Care plans record interventions to meet the needs of the residents. The evaluations of care document how the residents are progressing towards achieving their assessed needs and identified goals.

The activities programme is developed to be meaningful to the residents. There are activities that are designed for the different levels of care and complexity of the residents. There are one to one and group activities. There are specific activities for the younger people at the service.

There is safe and appropriate medication management. Staff who assist in medication management are assessed as competent to perform their roles. When appropriate, residents self-administer their medications.

The menu has been reviewed by the dietitian to meet the needs of people living in long term care.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has a current building warrant of fitness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are no restraints in use. When enablers are used, these are voluntary and the least restrictive option for the safety, comfort and independence of the residents. Staff receive ongoing training on strategies to minimise the use of restraint and enablers.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control management system includes surveillance and is appropriate for the nature of the service. The infection control coordinator collates monthly surveillance data and this is reported to the GM. Where there are any trends identified, actions are implemented. The infection control surveillance data are reported at management and staff meetings.

Expertise is available and can be sought as required.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	17	0	0	0	0	0
<b>Criteria</b>	0	39	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Complaints management is implemented to meet policy requirements. The complaints register sighted was up to date and identifies that at the time of audit there are no open internal complaints. Complaints processes are explained during the admission process as confirmed during resident and family/whānau interviews. Complaints forms are easily accessible at all times. A Health and Disability Advocate representative spoke to residents at the August 2016 resident meeting. This was confirmed in meeting minutes sighted.</p> <p>Two complaints have been received by the Health and Disability Commission. One complaint dated 06 October 2016 has been closed with no follow up required. The second complaint dated 10 October 2016 remains open. All actions have been taken to date as requested by the Health and Disability Commission.</p> <p>One complaint dated 17 February 2016 was resolved via the Nationwide Health and Disability Advocacy Service in April 2016.</p> <p>The Coroner's office requested information on the 21 November 2016 regarding a resident who was discharged from the service in June 2016. The service has this well documented including all community follow up information set up to assist a safe discharge. The required information has been forwarded to the Coroner's office.</p> <p>Staff verbalised their understanding and correct implementation of the complaints process. Complaints are a</p>

		<p>standing agenda item for staff and management meetings.</p> <p>The general manager confirmed complaints management information is used as an opportunity to improve services as required.</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>As identified in policy, the service ensures that full and frank information is shared with residents and family/whānau as appropriate. Information sharing was identified in the residents' files reviewed and confirmed during resident and family/whānau interviews.</p> <p>Management confirmed that interpreters would be used as required to ensure residents and family/whānau have a full understanding of issues discussed. At the time of audit, there are 10 residents with English as a second language (Samoan, Maori, Cambodian and Croatian) and the facility manager confirmed communication is maintained via family/whānau members and staff who speak the same language as the residents.</p> <p>Monthly resident meetings are used to exchange and share information as confirmed in meeting minutes sighted. Family/whānau are welcome to attend this meeting.</p> <p>Family/whānau and residents confirmed that they are kept well informed of any issues and that were invited to participate in care planning processes. This is documented in resident files as confirmed during reviews undertaken.</p> <p>All resident admission agreements sighted were signed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The facility can provide care for up to 74 residents with 62 beds occupied on the day of audit consisting of 36 rest home level care and 26 hospital level care residents. Seven residents (five hospital and two rest home) are under the age of 65 years. Included in the before mentioned numbers, five residents at hospital level care are under Accident Compensation Corporation (ACC) contracts. This has resulted in four files being reviewed using tracer methodology covering each contract held.</p> <p>The organisation has a business plan (dated 2016) which identifies the organisation's mission statement, vision and philosophy and shows the organisation's planning process to meet residents' needs. Strategic planning is undertaken yearly to ensure the services offered meet residents' needs. This is reflected in the business plan goals and objectives sighted which covers all aspects of service delivery. The business planning includes an assessment of the strengths and weakness of the service. There are formal management meetings two monthly to review progress with the set goals, with more informal verbal and email communications with the owner/general manager. An annual review of all goal set with outcomes to date was sighted.</p>

		<p>The facility manager, who has worked for the organisation since 1999 and at Tui House since 2009, moved into the current role over four years ago, and oversees all services. The facility manager is supported by the general manager (GM), a clinical nurse leader (CNL) who is experienced in aged care and a facility coordinator. There is a team of eight registered nurses at the facility and three hold current competencies to undertake interRAI assessments. Members of the management team attend the required hours of education and training covering clinical and management topics as is appropriate.</p> <p>Interviews with residents and family/whānau members confirmed they can speak with a member of the management team when they wish. No negative comments were made regarding services provided.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The policies and procedures are reviewed at least two yearly or sooner if there are changes to best practice or legislation. All policies reviewed during audit were up to date and reflect best practice. Links are identified with legislative documentation. Policies include updated pressure injury prevention and management and health and safety requirements. There is an archive system in place for obsolete documents.</p> <p>The key components of service delivery are standing agenda items for management and staff meetings. All data is collected monthly, collated, trended, reviewed by management and corrective actions put in place if any deficits are noted. Each key component has a set quality goal which is regularly reviewed and evaluation is documented to indicate how improvements have impacted on resident satisfaction and/or safety. Information is used to inform business and strategic planning processes. Staff, resident and family/whānau interviews confirmed any concerns raised have been addressed by management and verbal examples of quality improvements were given.</p> <p>Quality data information is shared with staff, residents and family/whānau as appropriate. Clearly documented information is available to all staff and the continued improvement process is overseen by management. Staff, residents and family/whānau interviewed confirmed they feel included and well informed about any new processes put in place. One recent quality initiative included a full review of wound care management following a less than satisfactory audit result in September 2016. The re-audit of wound care undertaken in November 2016 gained a 100% rating. All corrective actions were clearly documented and have been fully implemented in the everyday practice by staff.</p> <p>Corrective action processes inform the quality goals to ensure residents' needs are being met. Corrective action plans have been developed from all quality processes where a deficit has been identified to ensuring best practice standards are maintained. The corrective actions are decided by the management team and shared with staff at handover and at staff meetings. As staff implement the actions, their input into the evaluation of corrective measures taken is documented and discussed. If a corrective action appears not to be working, then actions are changed so the service can reach their required quality goals.</p> <p>Actual and potential risks are identified and documented in the hazard register and in the risk management</p>

		<p>plan. Newly found hazards and risks are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The GM and the CNL confirmed their understanding regarding their obligations in relation to essential notification requirements including pressure injury reporting under Section 31 of the Health and Disability Services (Safety) Act 2001. A section 31 report for a pressure injury was sighted.</p> <p>Policy is implemented by the service in relation to reporting, recording and monitoring adverse events. The service records all incidents and accidents. Any follow up required is undertaken in a timely manner and outcomes are monitored by management. Staff interviewed confirmed they report and record all incidents and accidents.</p> <p>Documentation confirmed that information gathered from incidents and accidents is used as an opportunity to improve services where indicated. One example relates to the follow up undertaken following an increase in falls in August 2016. Corrective actions undertaken were appropriate such as better use of sensor mats, the allocation of staff to a specific group of residents, and staff education. The evaluation of data shows that in September the falls rate was halved.</p> <p>Incident and accident information is reported at staff and management meetings. This is confirmed in minutes sighted. The review of residents' files showed that family/whānau are informed of incidents or adverse events. This was confirmed during interview with family/whānau members.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.</p> <p>Policies and procedures that identify employment practice reflect good practice and meet legislative requirements are implemented by the service. Job descriptions clearly describe staff responsibilities and accountabilities. The staff files sampled showed that staff have completed an orientation programme with specific competencies for their roles such as medication management. Staff annual appraisals are up to date.</p> <p>There is an annual education calendar in place for on-site education. This covers all aspects related to care provision. Education included regular staff attendance at off-site presentations and all staff confirmed during interview that they are supported and encouraged to undertake a wide range of education. The caregivers are encouraged to undertake recognised aged care educational papers.</p> <p>Resident and family/whānau members interviewed identified that residents' needs are met by the service in a professional manner.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy related to staff skill mixes and experience is reflected in the roster and meets contractual requirements. Every shift is covered by a RN and at least one staff member with a current first aid certificate. Documentation identified that most staff have a current first aid certificate.</p> <p>A review of the roster showed that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed they have adequate staff on each shift to allow all tasks to be completed in a timely manner and that residents' needs are met. Additional staff are rostered as required for example if there is a resident requiring end stage palliative care. This is supported by resident and families/whānau interviewed.</p> <p>Staff and management interviews confirm that all services are safely delivered to dual service beds. It was suggested that the cover provided be shown more clearly on the roster.</p> <p>The facility manager and CNL work Monday to Friday and share the after-hours on-call component. There are dedicated kitchen and housekeeping staff seven days a week. Activities are led by dedicated staff Monday to Friday for 6.5 hours in both rest home and hospital areas.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The observed medication procedures are implemented to meet legislative and best practice requirements. The medications are stored in the locked medication trolley and the nurse's office areas in both of the buildings. Medications that require refrigeration are stored in medication fridges in the rest home and hospital sections, the daily recording reflect guidelines. The processes for controlled drug management meet requirements. There are no standing orders. Residents who self-administer some of their medications (inhalers) are assessed as competent to do so.</p> <p>The medications are individually prescribed for each resident. The medications are delivered by the pharmacy in a pre-packed administration system. These medication packs and the signing sheets are checked for accuracy by the RN. The medication charts and prescriptions have the required information and are either hand written by the GP or a pharmacy generated medication chart that is signed by the GP. The three monthly medication reviews are recorded in the residents file and not on the medication chart.</p> <p>All staff who administer medications have been assessed as competent to do so.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food,</p>	<p>FA</p>	<p>There is a four-week rotational menu that has summer and winter variations. This menu has been reviewed by a dietitian in the last 12 months. Residents with specific nutritional needs have these met. The kitchen staff receive a copy of the nutritional requirements for each resident. There are kitchens in the rest home and hospital buildings. Residents are routinely weighed monthly or more frequently if there is a clinical need. Nutritional supplements are available to residents assessed as requiring these. Residents with</p>

<p>fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>specific nutritional needs, such as weight loss, have regular reviews by a dietitian (three monthly reviews in one of the files sampled). There are meal options and preferences that cater for the cultural and age mixes of the residents.</p> <p>Kitchen services are based on the food safety principles. There are appropriate processes in place for the purchasing, preparation and disposal of food that complies with current legislation and guidelines. Kitchen staff have completed food safety training.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The care plans record interventions that are appropriate to the resident's needs. There are additional care plans for specific needs that provide further documentation of any specialised needs. The resident's records are individualised and personalised to meet the assessed needs of the resident. The care provided was observed to be flexible and focused on promoting quality of life for the residents. The staff reported that the care plans provide adequate detail to provide the care and support that the residents require. The residents and family report satisfaction with the interventions provided.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The residents are included in meaningful activities at the care facility and are encouraged to participate in the community. There is an activities coordinator Monday to Saturday and staff assist with the planned and diversional activities on Sunday. The staff diversional therapist reported that they gauge the response of residents during activities and modify the programme related to the response and interests, the capability and cognitive abilities of the residents. There are group and one to one activities. There are specific activities for younger people at the service, with community and family/whanau participation and inclusion encouraged.</p> <p>The activities programme covers physical, social, recreational and emotional needs of the residents. The residents and families reported overall satisfaction with the level and variety of activities provided. Residents were observed to be going offsite with family/whanau.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluations are conducted at least six monthly and recorded on the care plan. The service uses the built in evaluation scores when the service reassesses the resident using the interRAI assessment as part of the evaluation process. The care evaluations are conducted for all the residents' needs and recorded how each of the resident's goals have been met over the past six months.</p> <p>When there are changes in the resident's needs, the service uses a short term care plan to capture these changes. The short term care plans identify the need, interventions and evaluation of the interventions. If the issue then becomes a long term need, these are then recorded and updated on the long term care plan.</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>	FA	<p>The facility undertakes all requirements to meet building warrant of fitness requirements. The current warrant of fitness expires 16 June 2017 and is displayed. This covers all the buildings as part of the service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There have been no changes to the layout of the building that has required changes to the approved evacuation scheme. The most recent evacuation drill was conducted within the last six months.</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>	FA	<p>The infection prevention and control surveillance data documented by staff is collated and monitored by the infection control co-ordinator. This data is reported at management and staff meetings as confirmed in meeting minutes sighted. The infection control coordinator (RN) has undertaken in depth infection control education with regular updates. The infection control coordinator knew who to contact for expert advice as needed. Most infections are treated from laboratory result testing by the GP. The infection control coordinator said very rarely a urinary tract infection may be treated on symptoms alone.</p> <p>The surveillance data collected is appropriate to the size of this aged care setting as demonstrated in the infection control programme. At facility level monthly analysis includes comparisons with the previous month, quality improvements and any significant comments. At governance level an annual analysis is undertaken to show if infections are decreasing and to set ongoing goals to continue infection rate improvements. The link between infection prevention and control is easily followed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	FA	<p>The service has policies and procedures for restraint minimisation and safe practice. There are clear definitions of a restraint and an enabler. There are appropriate policies and procedures to guide staff actions related to restraint and enabler use. On the day of the audit there were no restraints, with six residents with bed loops to assist mobility. These have been assessed these as enablers and are used voluntarily at the request of the resident. Staff interviewed understand the restraint minimisation and safe practice process.</p>

minimised.		
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## Specific results for criterion where corrective actions are required

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

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

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

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

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

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

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

No data to display
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End of the report.