

# Anglican-Methodist South Canterbury Glenwood HomeTrust Board

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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 and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Anglican-Methodist South Canterbury Glenwood HomeTrust Board
<b>Premises audited:</b>	Glenwood Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 2 October 2014 End date: 3 October 2014
<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>	35

# 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

Glenwood Home rest home is governed by the Anglican-Methodist South Canterbury Trust Board. The board retains oversight and guidance on service direction. Glenwood Home provides rest home care for up to 42 residents with a current occupancy of 35 residents. The facility manager has been in the role for one year and is experienced in health care management. The manager is supported by a clinical manager (registered nurse), two registered nurses and care staff. There is a quality and risk management programme in place. The care services promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed two of six improvements identified at the previous certification audit around completion of corrective actions, and infection control training for the infection control nurse. Further improvements continue to be required in relation to reviewing of risk assessments and aspects of care planning, timely referral to health and specialist services, aspects of medication management, and reporting of outbreaks.

This audit has identified improvements are required around completion of all internal audits, completion of orientation documentation and annual appraisals for staff, developing individual activities goals and plans for all residents, and dating decanted foods in the kitchen.

## 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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Staff communicate effectively with the residents. Residents and their families are kept informed, and there is documentation to evidence communication with families. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Glenwood home is managed by a qualified and experienced manager - with clinical oversight provided by a clinical nurse manager and two registered nurses. The facility manager and clinical manager are responsible for the implementation of the quality and risk management programme. The quality and risk management programme includes service philosophy, goals and a quality planner. Key components of the quality management system link to monthly quality meetings and monthly staff meetings. Residents are surveyed at two monthly meetings and resident and family satisfaction surveys are completed. There is an improvement required whereby all internal audits are completed as per the planner. The service has made improvements in relation to corrective action completion. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are appropriately managed. A recent outbreak has been effectively managed and opportunities for improvement identified and implemented. An improvement is required whereby all outbreaks are reported to appropriate authorities in a timely.

Discussions with families identified that they are fully informed of changes in health status. There is an orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Improvements are required whereby all new staff complete the orientation documentation and all staff have an annual appraisal completed. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Care plans are developed by either the clinical manager or the registered nurses who also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements continue to be required in relation to conducting and reviewing assessments and aspects of care planning. Improvements continue to be required in relation to referral to allied health and specialist services. The medication management system includes policy and procedures that follows recognised standards. The service has addressed a previous finding relating to documentation of medication orders. Staff responsible for medication administration receive training. Improvements are required whereby competency is conducted annually for all registered nurses, resident medications are reviewed by the residents' general practitioner at least three monthly, correct doses of medication are administered, and all administered medications are signed for. Self-medicating residents are appropriately supported to do so. A range of activities are available in the rest home and residents provide feedback on the programme.

Improvements are required around documenting activities goals and plans for residents. Glenwood has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded. Kitchen staff complete food safety training. Improvements are required whereby all decanted foods are dated with best before dates.

## 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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Glenwood displays a current building warrant of fitness certificate that expires on 1 May 2015.

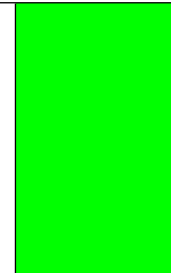
## Restraint minimisation and safe practice

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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The use of restraint is actively minimised. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were no residents assessed as requiring restraint or 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control coordinator has attended infection prevention education. The service has addressed and monitored this previous finding. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events and include all infections. The service has made improvements in this area. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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	10	0	5	3	0	0
<b>Criteria</b>	0	31	0	7	3	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>	<p>FA</p>	<p>A complaints policy and procedures are in place. A flow chart visually describes the complaints process. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms.</p> <p>Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service.</p> <p>Interviews with seven residents and two relatives are familiar with the complaints procedure and state any concerns or complaints are addressed.</p> <p>The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. There have been two lodged complaints for 2014. Evidence of a full investigation and resolution including communication with complainants is documented for each lodged complaint. Complaints are discussed at management meetings and staff meetings.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies are in place relating to open disclosure. Seven residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.</p> <p>A sample of incident reports reviewed, and associated resident files, evidence recording of family notification. Two relatives interviewed confirm they are notified of any changes in their family member's health status. The clinical manager and registered nurses can identify the processes that are in place to support family being kept informed.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.</p> <p>D16.1b.ii the residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p> <p>The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.</p> <p>D11.3 The information pack is available in large print and is read to sight-impaired residents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The rest home provides care for up to 42 rest home residents with 35 residents accommodated on the days of audit. Glenwood rest home is governed by the Anglican-Methodist South Canterbury Trust Board. The board retains oversight and guidance on service direction and has a constitution which guides the activities of the board. The facility manager was appointed in October 2013 and is experienced in health care management. She is supported by a clinical nurse manager who has been in the role for 10 months. The facility manager reports to the trust board monthly on issues relating to quality, complaints, health and safety, infections, incidents and accidents, occupancy, staffing and finances. There is a current quality plan for 2014/2015. The quality programme is managed by the facility manager and clinical nurse manager with assistance from the registered nurses and care staff. The service has an annual planner/schedule which includes audits, meetings, education and policy review time table. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents (link</p>

		<p>finding #1.2.3.6). The quality team incorporates the facility manager, the clinical nurse manager, the registered nurses, activities staff, health and safety rep, and two care givers. The committee meets monthly to assess, monitor and evaluate quality care at Glenwood rest home. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The mission statement sets out the vision and values of the service: 'to provide a community at Glenwood which provides a quality of life that recognises the dignity of people growing older'.</p> <p>D15.3d: The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</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>PA Low</p>	<p>The quality and risk management system is understood and implemented by the facility manager, clinical nurse manager, registered nurses and staff .</p> <p>A comprehensive set of policies and procedures are in place. The facility manager reports that new and/or revised policies are developed with input from staff. The facility manager signs off on all new policies. They are available for staff to read and to sign after reading.</p> <p>Policies and procedures are stored in hard copy at the facility. An external provider provides updates and reviews with the facility manager and clinical manager conducting further reviews to ensure that each policy aligns with the service. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed two-yearly unless changes occur more frequently. As a face sheet in each manual, and lists of policies and procedures that have been either recently developed or revised are documented.</p> <p>Key components of service delivery are linked to the quality and risk management programmes. The service has a business plan and current quality and risk management plan for 2014. The business plan includes goals relating to financial management, occupancy, staff retention and recruitment and building repairs and maintenance. The quality and risk management plan includes a focus on resident care, provision of effective programmes, meeting certification and contractual requirements, risk management and continuous improvement. Quality activities include meeting minutes and outcomes, complaints, feedback from residents and family, from staff, through the incident and accident reporting process and via internal audits. Various aspects of the service are monitored with audits conducted from July 2014 including resident and family satisfaction survey (currently underway), care plans (60%), medication management (95%), laundry (91%),</p>

	<p>activities programme (86%), food service (93%), infection control and hand washing (90%), complaints management (86%), resident cares and hygiene (100%), education programme (68%), and challenging behaviour management (92%). A process to measure achievement against the quality and risk management plan is in place. The facility manager is responsible for ensuring all internal audits are completed. Tasks are delegated to the registered nurses and to staff where appropriate.</p> <p>On review of the internal audit calendar for 2013 and 2014 it is noted that internal audits have not been conducted from July 2013 to June 2014. Internal audits not conducted in the last 12 months include cleaning and environment, restraint, and resident's rights. Advised by the facility manager that implementation of the internal audit planner had stalled prior to her commencing employment and that the service has been endeavouring to catch up. Improvements are required in this area.</p> <p>A resident/relative survey is currently being conducted. The last survey was conducted in April 2012. Survey outcomes will be communicated to residents via the next residents meeting. Residents/families are being surveyed around privacy and dignity, open disclosure, medical services, assistance from care staff, cleaning, food services, activities, laundry, safety and security, and gardening. Management meetings are held monthly (minutes sighted for 11 September 2014) and general staff meetings are held monthly (minutes sighted for 25 September 2014) with standing agenda items including incident and accident reporting, infection control, complaints and compliments, restraint, health and safety, internal audits and in-service education. Resident and family meetings are held two monthly – minutes sighted for 17 September 2014.</p> <p>Discussion is held at residents meetings around food, activities, concerns or complaints, personal cares, and laundry with minutes posted on the resident notice board.</p> <p>Data that is collected is analysed, evaluated and communicated to staff. Corrective actions are put into place where opportunities for improvements are identified. The service has addressed and monitored this previous finding. Results of the internal audits are discussed in the monthly staff meetings, and monthly management meetings.</p> <p>Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence.</p>
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		<p>Hazards are identified on the hazard register. The register is updated as new hazards are identified.</p> <p>D10.1: Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.</p> <p>D19.3: there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</p> <p>D19.2g: Falls prevention strategies include sensor mats and closely observing residents who are at risk of falling, use of mobility aids, correct footwear and exercises.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>D19.3b; There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p> <p>Adverse events (including but not limited to: falls, skin tears, bruising, challenging behaviours, medication errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by a registered nurse. Data is collected and collated on a monthly basis. Results are communicated to staff at the staff meetings (meeting minutes sighted).</p> <p>A sample of incident forms were reviewed for August 2014 relating to four residents and included medication errors, falls, skin tears and bruising. Staff advised that they contact family following an incident or accident and this is evident in incident forms or progress notes reviewed. Adverse events include an investigation. Follow up is conducted by a registered nurse and GP is notified if required. The clinical nurse manager investigates all events with further follow up by the facility manager. The incident reporting form documents the follow-up actions taken. Monthly incident/accident analysis is conducted and results discussed at staff meetings. Annual collation and analysis of reports is conducted.</p> <p>Overall statutory and regulatory obligations are understood by the facility manager. Examples include notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner. An outbreak of Norovirus occurred in August and September 2014 and involved 13 residents and 12 staff. This was reported to the DHB but was not reported to Public Health as per MOH guidelines.</p>

		<p>Improvements are required in this area.</p> <p>Improvement note: consider review of incident policy, incident reporting form and skin management policy to include reporting of pressure injuries as an adverse event.</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>	<p>PA Low</p>	<p>There are 44 staff employed at Glenwood which includes a full time facility manager, a full time clinical manager and two part time registered nurses. Other staff include caregivers, kitchen, housekeeping, and laundry and activities staff. Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file. Current practising certificates were sighted for the registered nurses. Practising certificates were also sighted for general practitioners.</p> <p>Six staff files were randomly selected for review (the clinical manager, two registered nurses, two caregivers and one activities person). Each staff file audited included evidence of a signed employment agreement and position description, and appropriate qualifications. Improvements are required in relation to evidencing completion of orientation programmes. First aid certificates sighted are current. Advised by the manager that the service is behind in conducting annual appraisals as evidenced in three of six files reviewed. Improvements are required in this area.</p> <p>Glenwood has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed caregivers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently. Interviews with four caregivers confirm their orientation to the service was thorough.</p> <p>Discussion with the registered nurses and caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and year to date for 2014 with a plan in place for the remainder of 2014. The annual training programme exceeds eight hours annually.</p> <p>Caregivers have completed either the national certificate in care of the elderly or are working towards completion. The diversional therapist is a certified trainer and assessor for the career force programme. Advised that one of the registered nurses is due to take over facilitation of the caregiver training programme.</p> <p>A system is in place to identify, plan, facilitate and record ongoing education for staff.</p>

		<p>All staff are required to attend training for the following: fire safety and evacuation, infection control, restraint minimisation, first aid, manual handling and topics relating to the code of rights including privacy, informed consent, the complaints process and open disclosure. One registered nurse has completed the interRAI training and competency and the clinical manager is in the process of completing this training. Attendance rates are recorded and evidence good levels of attendance by staff.</p> <p>Registered nurses and caregiver competencies available include medication administration knowledge and observed practice, insulin, and controlled drug administration. A tracking process is in place to ensure those who administer medications complete their annual medication competencies. One registered nurse does not have a current medication competency completed (link #.1.3.12.3).</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>A good employer policy is in place which includes staffing levels and skills mix. Staffing rosters were sighted. Part time and casual staff fill casual shifts and no agency staff are available. The facility manager works full time Monday to Friday. The clinical manager works fulltime (40 hours) and two registered nurses work 30 and 32 hours respectively. Registered nursing hours at Glenwood total 102 hours per week. The three registered nurses share the on-call component. The clinical manager and facility manager are available after hours for clinical and non-clinical service issues. There is further support from general practitioners, and St Johns ambulance service if required. Care staff interviewed advised that they are supported by the facility manager, the clinical manager and the registered nurses. Roster includes four caregivers on the morning shift – two long and two short shifts. Three caregivers are rostered on in the afternoons – two long shifts and one short shift. Overnight there are two caregivers on duty. Activities are provided by two activities staff – one DT and one activities coordinator - from 9.30am until 5.00pm Monday to Sunday. There are designated cleaning, kitchen and laundry staff.</p> <p>Staff turnover is reported by the facility manager as low. Staffing levels are altered according to resident numbers and acuity.</p> <p>One general practitioner was interviewed who confirms that staffing is appropriate to meet the needs of residents.</p> <p>Seven residents and two relatives confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly.</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>PA Moderate</p>	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care.</p> <p>The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by GP for six of 10 medication charts reviewed. Improvements are required in this area. Glenwood uses the Webster Pack System of four weekly blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy. Medication charts record prescribed medications by residents' general practitioners and include directions for use for all PRN medication orders. The effects of any PRN medication given is documented in progress notes as evidenced in files reviewed. The service has addressed and monitored this previous finding. Medication charts are kept in two medication folders. The medication folders include a list of specimen signatures.</p> <p>Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. Education on medication management occurred in 2013 and is scheduled for October 2014. Annual medication competencies are completed for senior care givers with medication administration responsibilities, one registered nurse and the clinical nurse manager. One registered nurse has not had medication competency completed. Improvements are required in this area. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and prn medication. On review of 10 medication charts and administration signing sheets, it was noted that errors have occurred in relation to one missed dose of medication, one incorrect dose of medication and three gaps in the signing sheets for three residents. Improvements are required in these areas.</p> <p>The service has adequate information and supervises the self-administration of medicines. Advised that one resident self-administers his eye drops and inhalers. These items are securely stored in a locked drawer in the resident's room. The resident is assessed three monthly for competency to safely self-administer medications.</p> <p>The service has in place and has implemented systems to ensure, a) residents</p>
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		<p>medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clinical intervention occurs, and c) adverse reactions and administration errors are recorded. Allergies are identified in residents' medication charts and resident files on the front page. There is a staff signature identification sheet in the front of the medication folders. One staff member was observed safely administering medications at the lunch time medication round.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>Glenwood has a workable kitchen and all food is cooked on site. There are two cooks and two kitchen assistants. D19.2: The two cooks and two of the kitchen hands have food safety training. One of the cooks has more than twenty years' experience. There is a four weekly rotating menu which has been developed by the main cook with oversight from a dietitian. The food service has been assessed by the local council and has a certificate for approved food service dated 23 June 2014. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served hot directly from the oven and oven top from food preparation containers to residents in the adjacent dining room or to their rooms as required. All food in the freezer and fridge is labelled or dated. Decanted food in the pantry is not dated. Improvements are required in this area.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook interviewed. Forms from the registered nurse to the cook were sighted for residents requiring special diets. Special diets are noted in a file in the kitchen, which can be viewed only by kitchen staff. Special diets being catered for include soft diets, and one lactose/dairy free diet. Weights are recorded weekly/monthly as directed by the registered nurses and/or dietitian. Residents report satisfaction with food choices, meals are well presented. Relatives interviewed report that their relatives are very happy with the meals. There is homemade baking for morning and afternoon tea. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen. There is a cleaning schedule, which is signed by member of staff</p>

		completing cleaning tasks.
<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>Glenwood provides services for residents requiring rest home level of care. Individualized care plans are completed. The four caregivers, two registered nurses and one clinical nurse manager interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment.</p> <p>Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.</p> <p>Wound care education was provided in 2013 and is planned for November 2014. Registered nurses have attended wound care study days in May 2014.</p> <p>Seven residents and two family members interviewed confirm their current care and treatments they and their family members are receiving meet their needs.</p> <p>Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed. Continence education was provided to staff in August 2014.</p> <p>All falls are reported on the resident accident/incident form and reported to the registered nurses and clinical manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral can be initiated as required.</p> <p>Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by the registered nurses. Care plans are goal orientated and reviewed at six monthly intervals. Care plans are updated to reflect intervention changes following review or change in health status. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation.</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</p>	PA Low	<p>There are two activities staff at Glenwood – one diversional therapist and one activities coordinator. Both are responsible for the activities planning and delivery of the activities programme. The activities staff job share the role and each work seven days a fortnight with activities provided each day of the week. The activities staff</p>

<p>service.</p>		<p>work 9.30 am to 5pm. The activities coordinator interviewed has been in the role for three years and has previously worked at a cook and a caregiver. Activities are provided in the lounge, dining area, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly and a weekly copy of the programme is available in the lounge and in each resident room. Residents have an initial assessment and social profile completed over the first few weeks after admission obtaining a complete social history of past and present interests and life events. Individual goals have been developed for one of six resident files reviewed. Improvements are required in this area.</p> <p>The programme includes residents being involved within the community with social clubs, churches and schools. The activities plan for each resident is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>Glenwood has its own van for transportation. Residents interviewed advised that they found the programme to be enjoyable and that they could choose which activity they wished to attend. The activities coordinators have current first aid certificates.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan review.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>All initial care plans are developed by a registered nurse on day of admission and resident comprehensive long term care plans developed within three weeks of admission. Long term care plans are evaluated six monthly or if there is a change in health status. There was documented evidence that care plan evaluations were completed in a timely manner in the five resident files sampled. Reassessment of resident needs was identified as a finding in the previous audit. Review of risk assessments and long term care plans for five resident's evidence that one of five residents has had all required risk assessments reviewed, and subsequent changes and updates made to the long term care plan. Four have not. Improvements continue to be required in this area. Care plan reviews are signed as completed by a RN. GP's review residents three monthly or when requested if issues arise or</p>

		<p>health status changes. Medication chart reviews for 10 medication files reviewed have not been conducted within the three month time frame (link finding #1.3.12.1). General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out his instructions, giving him full confidence in the management of the residents. Short term care plans were evident for current wounds, skin tears, urinary tract infections, previous diarrhoea and vomiting, depression and low mood, starting a new medication, weight loss, acute health changes, foot oedema, gout and dietary 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 is appropriately facilitated, or provided to meet consumer choice/needs.</p>	PA Moderate	<p>The service facilitates access to other medical and non-medical services. The manager and registered nurse interviewed confirms that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted.</p> <p>Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider. Previous audit identified that referral to allied health and specialist services had not been conducted when warranted. In the files reviewed, there is evidence of referral to wound care specialist, dietitian, physiotherapist, and podiatrist. One resident requiring specialist care has not been referred for specialist assessment. Improvements continue to be required in this area.</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 service displays a current building warrant of fitness which expires on 1 May 2015.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Previous audit identified that the infection control nurse had not had formal training specific to this role. The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse (RN). All infection control training is documented and a record of attendance is maintained. Infection control education was provided in February 2014 in relation to hand washing and hand hygiene. Infection control education is also provided at the orientation session for new staff and includes hand hygiene. All</p>

		staff complete an infection control questionnaire. The registered nurse has attended Bug control infection control education in November 2013. The service has addressed this previous finding.
<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>Infection surveillance is an integral part of the infection control programme and is described in Glenwood's infection control programme. Previous audit identified that infection surveillance data did not include all infections as per definitions. Monthly infection data is collected for all infections based on signs and symptoms of infection and includes bacterial, viral, and fungal. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. The service has addressed and monitored this previous finding. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the management meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. An outbreak of gastroenteritis occurred in August and September 2014 and involved 13 residents and 12 staff. This was reported to the DHB but was not reported to Public Health as per MOH guidelines (link 1.2.4.2). Information was provided to residents and visitors relating to the outbreak and visitors were advised to avoid entering the facility. Extra staff and resources were provided to manage and contain the outbreak. Residents are informed of infection prevention matters that are appropriate to their needs and this is documented in medical records</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Glenwood has comprehensive policies and procedures on restraint minimisation and safe practice. The clinical nurse manager is the restraint coordinator and confirms that the service promotes a restraint-free environment.</p> <p>Policy states that enablers are voluntary. There are no residents using enablers and no residents assessed as requiring restraint. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers.</p> <p>Documentation includes restraint register, restraint/enabler assessment forms, restraint consent forms, and a restraint plan in the resident care plan, monitoring</p>

		forms, and three-monthly evaluation forms should they be required.
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## 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)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Quality activities include meeting minutes and outcomes, complaints, feedback from residents and family, from staff, through the incident and accident reporting process and via internal audits. Various aspects of the service are monitored with audits conducted from July 2014 including resident and family satisfaction survey (currently underway), care plans (60%), medication management (95%), laundry (91%), activities programme (86%), food service (93%), infection control and hand washing (90%), complaints management (86%), resident cares and hygiene (100%), education programme (68%), and challenging behaviour management (92%). Where progress is less than expected (less than 95%</p>	<p>On review of the internal audit calendar for 2013 and 2014 it is noted that internal audits have not been conducted from July 2013 to June 2014. Internal audits not conducted in the last 12 months include cleaning and environment, restraint, and resident's rights. Advised by the facility manager that implementation of the internal audit planner had stalled prior to her commencing employment and that the service has been endeavouring to catch up.</p>	<p>Ensure that all internal audits are conducted as per the facility audit planner, to provide quality data for identification of areas for improvement.</p> <p>90 days</p>

		<p>achievement), corrective action plans are developed and implemented as evidenced in the quality programme. The service has made improvements in this area. A process to measure achievement against the quality and risk management plan is in place. The facility manager is responsible for ensuring all internal audits are completed. Tasks are delegated to the registered nurses and to staff where appropriate.</p> <p>A resident/relative survey is currently being conducted. The last survey was conducted in April 2012. Survey outcomes will be communicated to residents via the next residents meeting. Residents/families are being surveyed around privacy and dignity, open disclosure, medical services, assistance from care staff, cleaning, food services, activities, laundry, safety and security, and gardening.</p>		
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	<p>Overall statutory and regulatory obligations are understood by the facility manager. Examples include notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner. An outbreak of Norovirus occurred in August and September 2014 and involved 13 residents and 12 staff. This was</p>	<p>A recent gastroenteritis outbreak at Glenwood involved 13 residents and 12 staff. Advised by management that the DHB and needs assessment team were informed of the outbreak, however, notification to the relevant authority (Public Health) was not completed.</p>	<p>Ensure that timely notification occurs to relevant authorities in relation to notifiable diseases and outbreaks - as per MOH guidelines</p> <p>1 days</p>



		reported to the DHB but was not reported to Public Health as per MOH guidelines. Improvements are required in this area.		
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	Six staff files were randomly selected for review (the clinical manager, two registered nurses, two caregivers and one activities person). Each staff file audited included evidence of a signed employment agreement and position description, and appropriate qualifications. First aid certificates sighted are current. Glenwood has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed caregivers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently. Interviews with four caregivers confirm their orientation to the service was thorough.	Of the six staff files reviewed, two new staff members (one caregiver and one RN) who were both employed in July 2014, do not have evidence of completed orientation documentation on file.	<p>Ensure that all newly appointed staff complete orientation documentation and that this is reflected in their files.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	Discussion with the registered nurses and caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and year to date for 2014 with a plan in place for the remainder of	Three of six staff files reviewed evidenced that annual appraisals are overdue. One was due in December 2013, one due in April 2014 and one due in May 2014.	<p>Ensure that annual staff performance appraisals are conducted as per ARC contract requirements.</p> <p>90 days</p>

		<p>2014. The annual training programme exceeds eight hours annually.</p> <p>Caregivers have completed either the national certificate in care of the elderly or are working towards completion. The diversional therapist is a certified trainer and assessor for the career force programme. Advised that one of the registered nurses is due to take over facilitation of the caregiver training programme.</p> <p>A system is in place to identify, plan, facilitate and record ongoing education for staff. All staff are required to attend training for the following: fire safety and evacuation, infection control, restraint minimisation, manual handling and topics relating to the code of rights including privacy, informed consent, the complaints process and open disclosure. One registered nurse has completed the interRAI training and competency and the clinical manager is in the process of completing this training. Attendance rates are recorded and evidence good levels of attendance by staff. Annual appraisals have been conducted in the past, however, are now noted to be overdue. Three of six staff files reviewed commenced employment within the last 12 months and are not yet due for appraisals.</p>		
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<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA Moderate</p>	<p>The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by GP for six of 10 medication charts reviewed. Glenwood uses the Webster Pack System of four weekly blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy. Medication charts record prescribed medications by residents' general practitioners and include directions for use for all PRN medication orders. The effects of any PRN medication given is documented in progress notes as evidenced in files reviewed. The service has addressed and monitored this previous finding. Medication charts are kept in two medication folders. The medication folders include a list of specimen signatures.</p> <p>Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. Education on medication management occurred in</p>	<p>On review of 10 medication charts and administration signing sheets, it was noted that a) one regular dose of a medication was omitted from being administered to a resident; b) one incorrect dose of a drug was administered to a resident (3mg given instead of 2mg); c) three gaps in administration signing sheets for three residents was noted; d) four of ten medication charts reviewed did not evidence three monthly reviews by a GP - four charts show up to four months between reviews.</p>	<p>a)and b) ensure that the five rights plus three are adhered to when administering medications; ensure that all documentation relating to administration of medications is completed; d) provide evidence that GP's are conducting three monthly medication reviews as per the ARC contract.</p> <p>30 days</p>
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		2013 and is scheduled for October 2014. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and prn medication.		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	Annual medication competencies are completed for senior care givers with medication administration responsibilities, one registered nurse and the clinical nurse manager.	One registered nurse has not completed a medication assessment and competency.	<p>Ensure that all staff with responsibilities around medication administration have annual competencies completed.</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	The food service has been assessed by the local council and has a certificate for approved food service dated 23 June 2014. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served hot directly from the oven and oven top from food preparation containers to residents in the adjacent dining room or to their rooms as required.	On a tour of the kitchen, it is noted that decanted foods in the dry stores pantry are not dated with expiry dates.	<p>Ensure that decanted foods are labelled and dated with regard to best before dates.</p> <p>90 days</p>

		All food in the freezer and fridge is labelled or dated.		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>Activities are provided in the lounge, dining area, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly and a weekly copy of the programme is available in the lounge and in each resident room. Residents have an initial assessment and social profile completed over the first few weeks after admission obtaining a complete social history of past and present interests and life events. Individual goals have been developed for one of five resident files reviewed and activities plans are in place for four of five resident files reviewed.</p> <p>The programme includes residents being involved within the community with social clubs, churches and schools. The activities plan for each resident is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident</p>	<p>On review of five resident files, it is noted that four of five residents do not have activities goals developed and one of five residents does not have an activities plan developed.</p>	<p>Ensure that all residents have activities/diversional therapy goals and corresponding plans developed.</p> <p>90 days</p>

		needs. Participation in all activities is voluntary.		
<p>Criterion 1.3.8.2</p> <p>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.</p>	<p>PA Moderate</p>	<p>Long term care plans are evaluated six monthly or if there is a change in health status. There was documented evidence that care plan evaluations were completed in a timely manner in the five resident files sampled. Reassessment of resident needs was identified as a finding in the previous audit. Review of risk assessments and long term care plans for five residents' evidence that one of five residents has had all required risk assessments reviewed, and subsequent changes and updates made to the long term care plan. There are currently three wounds being treated and one heel pressure area. Wound assessments are completed for two of three of the wounds. This area continues to require improvement as identified at previous audit. Management plans are in place for three of three wounds, and there is evidence of referral to wound and vascular specialists. One of three wound care charts reviewed evidences wound dressings and progress is recorded for each dressing change.</p>	<p>a)A pain assessment for one resident on controlled drugs has not been reviewed since 29 April 2013; b) behaviour assessment for one resident with documented paranoia and agitation has not been conducted; c) short term care plan for one resident with low mood and depression is in place, however, lacks sufficient detail to guide staff in management of these symptoms; d) the long term care plan for one resident states that they are independent with toileting and are continent, however, progress notes report frequent episodes of urinary incontinence and regular assisted toileting by staff. The continence assessment has been reviewed in June 2014 and states that the resident is continent; e) one resident with an assessed high falls risk does not have this recorded on the long term care plan and mobility section of the care plan lacks sufficient detail to guide staff in the prevention and management of falls; f) wound assessment has not</p>	<p>a) conduct regular reviews and reassessment for residents with chronic pain issues; b) conduct behaviour assessments for residents with identified behavioural issues; c) ensure all short term care plans provide sufficient detail to guide staff in the caring for the resident; d) complete accurate assessments for residents and ensure that care plans reflect the resident's current care requirements; e) ensure all risk assessment outcomes are recorded on the long term care plan with sufficient detail to guide staff; f) conduct wound assessments for all residents with wounds; g) ensure that wound progress and monitoring is recorded at each dressing change.</p> <p>30 days</p>

			been recorded for one resident following removal of lesion and skin graft; g) on review of three residents with wounds, two of three plans evidence that monitoring and progress is not recorded for each dressing change.	
<p>Criterion 1.3.9.1</p> <p>Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.</p>	<p>PA</p> <p>Moderate</p>	<p>Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider. Previous audit identified that referral to allied health and specialist services had not been conducted when warranted. In the files reviewed, there is evidence of referral to wound care specialist, dietitian, physiotherapist, and podiatrist. One resident with resistant and disruptive behaviours, (behavioural and psychological symptoms of dementia), has not been referred for psychogeriatric assessment.</p>	<p>One resident with challenging behaviours (including paranoia, accusing residents and staff of stealing, arguing with other residents, being confrontational and periods of agitation) has not been referred for specialist assessment.</p>	<p>Ensure referral to specialist services is conducted for residents with identified needs and requirements.</p> <p>30 days</p>

## 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.

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End of the report.