

Summerset Care Limited - Summerset By The Lake

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:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset By The Lake
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 October 2015 End date: 28 October 2015
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	8

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
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

Summerset by the Lake is able to provide rest home level care for up to 18 residents in serviced apartments within the retirement village complex. On the day of the audit, there were eight residents in the apartments receiving rest home level of care. The service is managed by a village manager/registered nurse who is supported by a regional operations manager, office manager, registered nurse and care team. The residents spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, management, general practitioner and staff.

Environmental improvements include ongoing refurbishment of apartments and the communal areas.

There were no previous findings from the certification audit.

This audit identified improvements required around corrective actions, performance appraisals, documented interventions, activity plans and aspects of medicine management.

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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Residents and families are kept informed on all aspects of the service and resident health. Residents and their family are provided with information on the complaints process on admission. Complaints are managed in a timely manner. Staff are aware of the complaints process and to whom they should direct complaints.

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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Services are planned, coordinated and are appropriate to the needs of the residents. The village manager/registered nurse is responsible for the day-to-day operations of the facility. She has been in the role eight weeks and completed a Summerset management orientation and leadership course. Summerset quality management processes are reflected in organisational and service business plans, goals and objectives, and policies. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Staff document adverse, unplanned and untoward events.

Residents receive appropriate services from suitably qualified staff. Recruitment is managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff with ongoing education and training provided.

There are adequate numbers of staff on duty to ensure residents are safe. A full-time registered nurse is employed, with 24 hour on call shared with the village manager.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurse completed the assessments, resident centred care plans and evaluations within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans are individualised.

A recreational therapist develops and provides a four day a week activity programme. Community links are maintained. There is volunteer involvement, visiting entertainers and outings.

Staff responsible for the administration of medications complete annual medication competencies and education. All medication charts had photo identification and allergy status.

The food service is contracted with all meals prepared on-site. Resident's individual dietary needs are identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

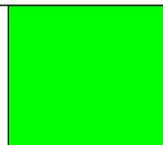


Standards applicable to this service fully attained.

There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

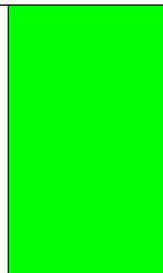


Standards applicable to this service fully attained.

There are documented policies and procedures around restraint use and use of enablers. There were no restraints or enablers in use on the day of audit.

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 control programme and its content and detail were appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) monitors infection rates. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training on infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	11	0	4	1	0	0
Criteria	0	34	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Residents confirmed their understanding of the complaints process. Six staff interviewed were able to describe the process around reporting complaints.</p> <p>An electronic complaints register includes verbal and written complaints. There is evidence to confirm that the one complaint received in 2014 and one in 2015 were managed in a timely manner, including acknowledgement, investigation, timelines, corrective actions when required and resolutions.</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>An open disclosure policy describes ways that information is provided to residents and families. The admission pack gives a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. An interpreter is provided as required. Regular contact is maintained with family, including if an incident or care/health issue arises as documented on accident/incident forms and family consultation record in the resident files. No relatives were available for interview during the audit. Four residents interviewed stated they were well informed.</p> <p>There are three monthly residents meetings where any issues or concerns to residents are able to be</p>

		discussed. The village manager has introduced a monthly manager's forum/morning tea in the cafe with residents. This forum was observed to be well attended and interactive. Bi-monthly newsletters are sent out to families.
<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>Summerset by the Lake is certified to provide rest home level care for up to 18 residents in serviced care apartments. An additional room is utilised for respite care. On the day of the audit, there were eight rest home residents and no residents on respite care. The service provides home based services to clients in the care apartments and village. There is a retirement village attached as part of the complex, with overall management of the site provided by a village manager.</p> <p>A strategic plan is in place for the organisation. The 2014 business plan has been reviewed. The 2015 business plan for the service is linked to the strategic plan and includes annual goals and objectives around health and safety, marketing and community links.</p> <p>The organisation's clinical quality manager oversees quality.</p> <p>The village manager has been in the role eight weeks, has had 12 years previous experience as a business care manager in aged care and holds a diploma in business management. She is a registered nurse with a current practicing certificate and has completed her orientation, first aid certificate and two day leadership programme with Summerset.</p> <p>An office manager supports the village manager. A full-time registered nurse was appointed two months ago after completing the competency assessment programme in June 2015. The service has been actively recruiting for a clinical nurse leader.</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>	PA Low	<p>A quality and risk management plan is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Village managers are responsible for policy implementation as directed from head office.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, and pressure areas. Data is collated and benchmarked against other Summerset facilities to identify trends and quality improvements.</p> <p>A care satisfaction survey is conducted annually. Results for 2015 show an overall satisfaction-rate of 92%. An analysis and action plan has been developed for identified areas for improvement.</p> <p>The service completes internal audits as per the annual audit programme. Not all corrective action plans</p>

		<p>developed because of internal quality activities have been completed.</p> <p>Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>The village manager, who has completed stage one and two health and safety training, oversees the health and safety programme. Health and safety discussion and quality data is incorporated into the monthly quality improvement meetings (minutes sighted). Staff complete hazard identification forms for identified/potential hazards. A current hazard register is in place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the electronic quality and risk management programme (SWAY – Summerset Way). Incidents and accidents are reported on the incident forms. The registered nurse was notified in a timely manner as evidenced in the progress notes and accident/incident form on the 12 forms viewed in resident files. The incidents forms are then reviewed and investigated by the village manager. If risks are identified, these are processed as hazards.</p> <p>Discussions with the village manager confirmed their awareness of statutory requirements in relation to essential notification. There have been no outbreaks or essential notifications since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of the village manager/RN and full-time RN are current. Five staff files were reviewed (three caregivers and two registered nurses). Evidence of signed employment contracts, job descriptions, orientation, and training was available for sighting. Annual performance appraisals have not been conducted annually for all staff files reviewed. Newly appointed staff complete an orientation that is specific to their job description. Care staff interviewed described the orientation programme that includes a period of supervision.</p> <p>The service has an annual training schedule for in-service education that links with policy reviews, internal audits and Careerforce modules and on-line training. External training is available for RNs. The education has been implemented and attendance recorded. Staff members who are unable to attend education are required to read the education note. The service has a company Careerforce assessor.</p> <p>Staff complete competencies relevant to their roles. The service has access to an organisational InterRAI trained RN for the assessment of all new admissions. The RN is scheduled to attend InterRAI training.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The full-time registered nurse is on duty Sunday to Thursday during the day. The village manager is full-time Monday to Friday. Both RNs share the on-call. There are two care staff on duty for mornings, afternoons and night shift. Home-based support services are provided by one of the staff on duty allocated to the personal cares. There is at least one staff member on duty at the care centre at all times. Staff reported that staffing levels and the skill mix was appropriate and safe. Residents advised that they felt there was sufficient staffing.</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>There are policies and procedures in place that follow recognised standards and guidelines for safe medicine management. The RNs and designated caregivers, who are responsible for the administration of medications, complete annual medication competencies and education. Education has been completed for the implementation of a new electronic medication system being introduced within the next week. All incoming medications are checked against the medication charts. Standing orders are not used. There was a self-medication competency and monitoring in place for one resident who was self-medicating.</p> <p>Eight resident medication charts were reviewed. Medication charts have photograph identification and allergy status. The prescribing of regular and prn medications meets legislative requirements. Shortfalls were identified around the administration of one 'as required' medication and GP medication chart reviews.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The provision of the meal service is contracted to an external company with all meals cooked on-site. The dietitian has reviewed the summer menu (in place). Meals are transported in a bain marie to the dining room. There are alternative meal options available and resident likes/dislikes and preferences are known and accommodated. Special diets include gluten free, texture modified and diabetic desserts. The chef manager receives a dietary profile for each resident and is notified of any dietary changes.</p> <p>The kitchen is well equipped. The fridge, freezer and dishwasher have daily temperatures recorded. End cooked food temperatures are recorded daily. Cleaning schedules are maintained. Chemicals are stored safely when not in use. Staff were observed wearing correct personal protective clothing.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training.</p> <p>Residents have the opportunity to feedback on food services through regular resident meetings. There are weekly village manager/chef manager meetings.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Residents interviewed stated their needs were being met. There is documented evidence on the consultation record of relatives being informed of any health changes, GP visits and care plan reviews. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation.</p> <p>Dressing supplies are available and a treatment room is stocked for use. Continence products are available and residents' files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.</p> <p>There was an initial wound assessment and an ongoing assessment and treatment plan in place for one resident with a skin tear. There were no other wounds. There is access to a wound nurse specialist if required.</p> <p>Interventions in long-term care plans were not completed for residents with weight loss. The service has identified a shortfall around weight management and has purchased chair scales as part of the action plan.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>The service employs a recreational therapist for 15 hours per week Monday to Thursday to provide an activity programme for residents in the care apartments. The current recreational therapist has been in the role since July 2015 and receives support from a diversional therapist from another Summerset facility and from head office.</p> <p>The programme is planned a month in advance and includes activities that are appropriate to the residents' interests and abilities. Links are maintained with the community. Interdenominational church services are held regularly. Several volunteers are involved in activities including reading, poetry and exercises. The care staff ensure activities are provided in the weekends as per the programme. Activity plans have not been completed for all residents.</p> <p>Residents interviewed commented positively on the activities offered. Residents have the opportunity to provide feedback on the programme at the monthly resident meetings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	<p>FA</p>	<p>There is evidence of resident and family involvement in the review of resident centred care plans. The registered nurses evaluate all initial care plans within three weeks of admission. Written evaluations were completed in all files sampled. There is evidence of multi-disciplinary team involvement in the reviews. Short-term care plans had been evaluated by the RN and either resolved or transferred to the long-term care plan for ongoing problems.</p>

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<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>A current building warrant of fitness that expires 28 November 2015 is posted in a visible location. There has been ongoing upgrading of furnishings in the communal lounge, sunroom and dining room. Twelve rooms have been refurbished in the past year. Furniture is being replaced that is appropriate for rest home level of care.</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>Infection monitoring is the responsibility of the infection control coordinator (registered nurse). The infection control policy describes routine monthly infection surveillance and reporting. Monthly surveillance activities are appropriate to the acuity, risk and needs of the residents. There have been no outbreaks. Infection types and numbers are entered into the 'SWAY' database, which generates a monthly analysis of the data. The analysis is reported to the monthly quality improvement meetings, which includes infection control. Infection control is discussed at management meetings and staff handovers. Organisational benchmarking occurs against facilities of similar size.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers, which were last reviewed in March 2014. The village manager is overseeing the restraint coordinator role until the appointment of a clinical nurse leader. There were no residents using enablers or restraints on the day of audit.</p> <p>Staff have received training around restraint minimisation and the management of challenging behaviour and completed restraint competencies.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>The service has a 2015 internal audit programme that includes clinical, environmental, health and safety, and infection control audits that have been completed as per schedule. Corrective actions have not been developed for all audit deficits or when opportunities for improvements have been identified. Staff are informed of audit findings and quality initiatives through the quality improvement meetings.</p>	<p>Corrective action plans have not been raised for a number of 2015 audits with partial compliance. Examples include medication audit (February and August), care plan evaluations (February and June), safe manual handling and security audits. Where corrective actions have been raised, these do not always evidence follow-up and sign-off of resolution (eg, recreation and medicine management audits).</p>	<p>Ensure corrective action plans are raised for audit partial and non-compliances. Ensure all corrective actions are followed-up and signed-off as resolved.</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>	<p>PA Low</p>	<p>There is an annual education schedule that is being implemented and covers more than eight hours annually. Opportunistic education is provided in addition to mandatory training topics. Staff provide feedback on training at the facility meetings. Individual training and education needs are discussed as part of the performance appraisal system. Three of five staff files contained an annual performance appraisal.</p>	<p>Annual appraisals were overdue as of March 2015 for two out of five staff files reviewed.</p>	<p>Ensure staff appraisals are conducted annually.</p> <p>180 days</p>
<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>Six of eight medication charts evidenced three monthly GP review. All regular and 'as required' medications charted met legislative prescribing requirements. Signing sheets reviewed for regular medications corresponded with the medication chart.</p>	<p>i) Two of eight medication charts did not evidence three monthly GP review; ii) One 'as required' medication prescription was for two weeks only. Staff had continued to administer the medication beyond the two-week period.</p>	<p>i) Ensure that medication charts are reviewed at least three monthly by the GP; ii) Ensure 'as required' medication is administered as per the prescription.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Risk assessment tools for continence, falls, pressure area, pain and dietary profiles were completed on admission in the five resident files reviewed. Risk assessments are reviewed at least six monthly or earlier for any changes in health status. Short-term care plans were in place for short-term/acute needs. Monitoring forms such as behaviour charts and pain charts were in use.</p>	<p>The resident centred care plans for two residents with identified weight loss did not reflect the resident's current weight and nutritional status.</p>	<p>Ensure care plans document interventions for weight loss.</p> <p>60 days</p>

<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>	<p>PA Low</p>	<p>The recreational therapist has completed an activity assessment and communication assessment in consultation with the resident/family in five of five resident files reviewed. Monthly progress notes are maintained. Three of five residents have activity plans completed, however, these have not been reviewed six monthly.</p>	<p>i) There are no activity plans in place for two of the five resident files reviewed; ii) The activity plans for three residents have not been reviewed at the same time as the care plan.</p>	<p>i) Ensure all residents have an individualised activity plan in place; ii) Ensure activity plans are reviewed at the same time as the care plan.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.