# Bethsaida Trust Board Incorporated - Bethsaida Retirement Village

## Introduction

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

The audit has been conducted by The DAA Group 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bethsaida Trust Board Incorporated

**Premises audited:** Bethsaida Retirement Village

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 18 May 2016 End date: 19 May 2016

**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:** 40

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

## General overview of the audit

The Bethsaida care facility is situated in Blenheim, in the Marlborough region. It provides residential care for up to 43 residents who require hospital or rest home level care. Occupancy on the day of the audit there were 40 residents. The facility is operated by the Bethsaida Trust Incorporated which is a registered charitable trust.

This certification audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of policies and procedures, residents’ and staff files, observations, and interviews with residents and their families, management, staff and the board chairperson. Two general practitioners were also interviewed. Residents and family members interviewed provided very positive feedback on the care and services provided by the facility.

One area was identified as requiring improvement around timeliness of the reviews of activity plans. An area which is outside the control of the provider, with a negligible risk, concerning training was also noted.

## Consumer rights

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| --- | --- | --- |
| 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. |

Care provided to residents is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected.

Appropriate policies, procedures, community connections and documentation ensures culturally appropriate support can be provided.

Residents interviewed feel safe, there is no sign of harassment or discrimination, staff communicated effectively and residents are kept up to date with information. Residents, or their enduring power of attorney, sign a consent form on entry to the service with separate consents obtained for specific events.

The service informs residents and their families of how to access the Nationwide Health and Disability Advocacy Service and encourages residents to maintain connections with family, friends and their community and to access as many community opportunities as possible.

An effective complaints system is in place with all response timeframes clearly documented. Any issues raised in the past year were resolved satisfactorily.

## Organisational management

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| --- | --- | --- |
| 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. |

The care facility is managed by an experienced and well qualified manager who provides management of the whole Bethsaida Village complex which includes both the care facility and a small retirement village. She is supported by the trust board and the senior managers. Planning is detailed and is responsive to any changes required both at legislative and facility level.

A detailed quality and risk management system is in place with regular reporting. There is a quality plan which includes an annual calendar of internal audit activity and monitoring of the various components, including health and safety, infection control, medication, care plans, administration functions, human resources processes and quality improvements. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective action planning, feed into the quality improvement process to manage any risk and ensure continuous quality improvement occurs.

A recruitment and appointment system is in place and staffing levels meet all the requirements. A comprehensive training programme is evident to maintain a high level of competence of all staff. Staff reported high job satisfaction and commented on the support received from both management and colleagues.

Residents’ information is accurately recorded, and all information was securely stored and not accessible to the public. Service providers used up to date and relevant residents’ records.

## Continuum of service delivery

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| --- | --- | --- |
| 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 low risk. |

The organisation works closely with the Needs Assessment Co-ordination Service to ensure access to the service is efficient and relevant information is provided, whenever there is a vacancy.

Residents’ needs are assessed on admission by the multidisciplinary team. All residents’ files sighted provided evidence that needs, goals and outcomes are identified and reviewed on a regular basis, with the exception of the residents’ activity plans. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

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

Well defined medicine policies and procedures guide practice. Practices sighted were consistent with these documents.

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

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

The facility is well maintained. The residents’ rooms and the communal areas are spacious, clean, well ventilated and kept at a comfortable temperature for residents. The rooms all have their own bathrooms and individual heating systems. Well maintained and safe outside areas are easily accessed for all residents.

The building has a current building warrant of fitness.

The management of waste and hazardous substances is safely managed by staff who are trained in these processes.

Emergency procedures are well documented for ease of use and clear instructions are located in a number of areas around the facility. There is also a of fire hose in each wing. Regular fire drills are held and the facility is organised into a number of fire cells to minimise any disruption in the event of any fire emergencies.

Adequate back up supplies, including food and water, are stored on site in case of an emergency and a back-up generator starts up within seconds of any power outage.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

The organisation has policies and procedures that meet all the requirements of the standard and these are followed for enabler and restraints in use. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews is occurring. The use of enablers is for the safety of residents in response to individual requests and are reviewed regularly. Staff education is current.

## Infection prevention and control

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

The service provides an environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control nurse reporting directly to the facility manager who reports to the board.

There is an infection prevention and control programme for which external advice and support was sought; this is reviewed annually. An infection control nurse is responsible for this programme, including education and surveillance.

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

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. Surveillance results are benchmarked with an external provider. The results of surveillance are reported through all levels of the organisation, including governance.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 48 | 1 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 99 | 1 | 1 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Interviews with residents and family members of residents verified services provided complied with consumer rights legislation.  Policy documents, staff orientation programme, in-service training records, education programmes, interviews with staff, and satisfaction surveys verified staff knowledge of the Code of Health and Disability Services Consumers’ Rights (the Code).  Clinical staff were observed to explain procedures, seek verbal acknowledgement for a procedure to proceed, protect residents' privacy, and address residents by their preferred name. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The informed consent policy describes all procedures to ensure the resident’s rights to be informed of all procedures undertaken.  Documentation, observation and interviews provided evidence that information is provided to make informed choices. Informed consent is understood and is included in the admission process. The resident, and where desired family/whanau, are informed of changes in the resident’s condition and care needs, including medication changes. Residents and where appropriate family, are included in resident’s six monthly multidisciplinary reviews. Residents’ choices and decisions, including advance directives, are recorded and acted on where valid. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The service recognises and facilitated the rights of residents and their family/whanau to advocacy/support by persons of their choice. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilised appropriate community resources, both internally and externally. Residents and their families are aware of their right to have support persons. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations, with the support of the service. The service encourages the involvement of families/whanau in the provision of care, and the activities programme actively supports community involvement. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. These are provided in the first instance to all new residents on admission. Forms are also available in the reception area. The facility manager takes responsibility for investigating and managing complaints. All complaints are recorded in the complaints register. Every complaint is then entered into the quality reporting system.  The complaints register was reviewed and the two complaints received over the past six months were well documented with copies of all responses made. Both meet the required timeframes as per the organisational policy and were resolved satisfactorily. The health and safety/quality committee review any complaints at their regular meetings. Corrective actions are initiated as appropriate and form part of the quality improvement process.  All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Interviews, observations and documentation verified residents are informed of their rights. Information on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service is displayed and accessible to residents.  Discussion, clarification and explanation on the Code and the Advocacy Service occurred at admission. Legal advice is able to be sought on the admission agreement or any aspect of the service. Information is provided on the facility’s range of costs and services. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Policy identifies that procedures are in place to ensure residents are kept free from discrimination, harassment, abuse and neglect, including the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. Residents receive services that treat them with respect and have regard for their dignity, privacy, sexuality, spirituality and independence.  Staff demonstrated policy awareness and responsiveness to residents’ needs. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Documentation is in place to guide staff practices to ensure residents’ needs are met in a manner that respects and acknowledges their individual cultural values and beliefs. Policy states that this is to be identified upon entry as part of a resident’s care planning process. The organisation had a documented Maori Health Plan which identified their priorities related to culturally safe services. The service recognises the relationship between iwi and the Crown and the principles of the Treaty of Waitangi (Partnership, Participation and Protection). Whanau relationships and involvement in care are recognised.  Local organisations support the needs of Maori residents and will assist if required. Staff receives education in relation to cultural safety and the Treaty of Waitangi. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Policy identifies that residents receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values and beliefs.  Evidence verified residents received and are consulted on culturally safe services which recognised and respected their ethnic, cultural and spiritual values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policy indicates that residents are to be free from all forms of discrimination, coercion, harassment and exploitations. Orientation/induction processes inform staff on the Code. The company’s house rules, policies and procedures provide clear guidelines on professional boundaries and conduct, and inform staff about working within their professional boundaries. Interviews verified staff understanding.  Residents interviewed felt safe and received a high standard of support and assistance and reported there was no sign of harassment or discrimination. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages good practice. Policies sighted were current, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies reflected current evidence based best practices, which are monitored and evaluated at organisational and facility level. Practice was verified to be in line with policy.  A range of opportunities are provided to enable staff to provide services of a high standard. The general practitioners’ (GPs) interviewed confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policy identified that interpreter services are available and offered to residents with English as a second language.  The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided. Communication with relatives is documented in the residents’ communication records and incident forms and verified an environment conducive to effective communication. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bethsaida Trust Board is governed by a board of trustees which is made up of six representatives from the local community. The Business Plan for 2012 – 2017 was updated in 2016 and this details the purpose, values and mission along with goals which are all regularly reviewed. These are integrated into the planning process. A comprehensive suite of policy and procedure documents was reviewed with the focus being on quality aged care provision. The business plan details the planned goals and actions for the current year.  The manager reports to the chair of the board and provides the board with a monthly report at their regular meetings. The board chair reported the manager has the full confidence of the board and takes responsibility for the operational activities of the facility. The manager has been in the role for three years, is a registered nurse and has had significant previous experience in the aged care sector. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During any absences by the manager, the role is covered by the clinical nurse manager who has done this successfully on a number of occasions. The board of trustees are also available if additional support is required and confirm they are happy with arrangements in the absence of the manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is a detailed quality and risk management plan which is reviewed annually. A registered nurse has been appointed to take specific responsibility for managing the quality framework and reporting to the quality committee and the manager. A range of quality indicators are being monitored throughout 2016 including medication, adverse events, infection control, health and safety, pressure injuries, skin care, complaints, restraint, education and training and all quality improvement activities.  The quality improvement plan includes an annual calendar of internal audit activity and the month when each audit is completed. The results of these are analysed and relevant corrective actions raised if needed.  The quality management system is informed by regular reporting and analysis of data collected from all the indicators with the information fed into an electronic quality system. Collated reporting, including graphed information, is produced monthly and benchmarked against a number of other facilities. These are reviewed at the quality meetings held two monthly. Corrective actions are put in place when required and monitored regularly. Staff meet in a number of forums where the quality reporting and initiatives are discussed. Staff who are unable to attend any of these meetings must read and sign off the meeting minutes to ensure the information is shared across the facility. The minutes of the quality committee for the current year were sighted and the agenda covered all the relevant quality and risk reports. Resident surveys also inform quality information and the residents’ three monthly meetings have updates on quality initiatives as appropriate.  The manager confirmed reporting on quality is completed on a monthly basis which includes results from internal audits and the resulting corrective actions which are also monitored regularly. The management reports to the board reviewed included the summarised information of quality indicators.  Policies sighted are all current and are reviewed regularly. A document control system is in place.  The facility risk management schedule detailed risk factors, risk categories, impact and probability scales and impact of each after controls are applied, actions to be taken to control each risk and the relevant positions and committees responsible for them. These risks are reviewed continuously.  Staff interviewed reported they are involved in and kept informed of all the quality activity at the facility. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Appropriate policy and guidelines have been developed to guide reporting and responses for incidents/accidents and serious harm. The open disclosure policy clearly describes the process for keeping residents and families informed appropriately. Categories and definitions of adverse events with a risk level table is included.  All individual events are followed up by the registered nurse on duty daily. They are then reviewed by the clinical nurse manager and the facility manager and details entered into the quality reporting system. Any immediate actions and / or responses that are required are implemented. Relevant prompts, process requirements and investigation details are flagged in the system to ensure all procedures are completed and closed off. This includes notification of family and medical professionals where relevant.  A monthly analysis of all incident / accident reports are categorised according to each event type. The quality committee then review the collated and analysed data at their meetings and raise any other corrective actions that are required and monitor those already in place.  The events register was reviewed. A copy of each incident form was also filed onto the resident’s notes. Relevant corrective actions raised are communicated to staff, reviewed, progress tracked and preventative measures implemented. Staff interviewed across all service areas understood they are responsible for reporting and responding to incidents and confirmed they understand and follow the required processes.  The manager confirmed she reports any incidents that require essential notification to the relevant authority at the DHB or to Worksafe NZ. This is also flagged in the electronic quality system when an event is entered. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Negligible | A comprehensive set of policies and procedures have been implemented and reflect good employment processes. All recruitment is managed by the manager, with support from the clinical nurse manager for all clinical appointments. All relevant police vetting and competency checks have been completed prior to any appointments. Professional qualifications are verified and filed. Other professionals who are independent of the facility as well as independent contractors also have relevant checks completed. All annual practising certificates (APCs) were current and securely filed. Current competencies for the facility interRAI assessors were sighted.  The staff files reviewed have the required documentation completed and current performance appraisals had been completed.  All staff have received a comprehensive orientation. This covered the introduction to the facility and the policies. A comprehensive annual training plan is in place. These covered the requirements for aged care providers. The manager also reported she keeps individual training records to monitor the attendance of staff at training sessions. The clinical nurse manager is responsible for the clinical training programme and facilitates outside presenters as needed. All staff are required to attend training sessions directly associated with their role as well as full staff attendance at emergency evacuations training. There are a number of modules that are compulsory for all staff and this includes training about the Code, infection prevention and control, skin care, manual handling, challenging behaviour, complaints and informed consent. Care staff are expected to complete Careerforce training programmes.  Records reviewed evidence comprehensive training occurs for staff at the facility. Staff interviewed report they have significant training opportunities and confirmed management are very encouraging to staff to upskill themselves.  A total of three registered staff are interRAI trained and pressure injury training has been completed by all care staff. A training concern around the lack of availability for interRAI training was identified which has resulted in delay in the completion of some of the interRAI assessments and reviews. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The organisation’s leave and rostering policy describes relevant staff/skill mix required at the facility. All rosters are maintained by the clinical nurse manager and are prepared monthly in advance using the facility template to ensure safe staffing levels are in place.  The rosters were sighted for the current month. These confirmed adequate cover for the acuity needs of current residents. The clinical nurse manager reported any absences are able to be covered as there are a number of casual staff able to be called on. At least one staff member is on duty at all times who has a current first aid certificate. There is 24 hour seven day a week (24/7) RN coverage. Staff reported they are happy with the staffing levels. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There was no personal or private resident information on public display during the audit. The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all resident's information sighted. Clinical notes are current and integrated with GP and auxiliary staff notes. The files are kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers are all recorded in each resident’s record.  Archived records were being held on site in a secure room. These are catalogued for easy retrieval. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | An interview with the facility manager verified when the need for service had been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner.  Information about the service, includes full details of the services provided, its location and hours, how the service is accessed and identifies the process if a resident requires a change in the care provided.  Files reviewed contained completed assessments. Signed admission agreements meet contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is comprehensive and identifies all aspects of medicine management.  A safe system for medicine management was observed on the days of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administers medicines is competent to perform the function they manage. Administration records verify compliance with prescribed instructions.  Controlled drugs are stored in a separate locked cupboard. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.  The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.  The GP’s signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart.  Residents who self-administer their medicines have appropriate processes in place to ensure this is managed in a safe manner.  Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.  Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident’s medication chart. PRN medication requests include indications for use. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food, fluid and nutritional requirements of the residents are provided in line with recognised nutritional guidelines for older people as verified by the dietitian’s documented assessment of the planned menu (January 2016).  A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet residents’ nutritional needs, were sighted.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.  The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule was sighted as was verification of compliance.  Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.  There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | An interview with the facility manager verified a process existed for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry is communicated to the referrer, resident and their family or advocate in a timely and compassionate format. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission, residents have their needs identified through a variety of information sources that includes the Needs Assessment and Service Coordination (NASC) agency, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident’s bedroom with the resident and/or family/whanau present if requested.  Over the next three weeks, the RN undertakes a range of clinical assessments, which are reviewed six monthly or as needs, outcomes and goals of the resident change. In three of ten files reviewed assessments did not include the services use of the interRAI assessment tool (refer 1.2.7.5).  A medical assessment is undertaken within 48 hours of admission and reviewed monthly, if a resident's condition is changing, or three monthly if the GP documents the resident is stable. A multidisciplinary review is undertaken every six months. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The assessment findings, in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support the resident needs to meet their goals and desired outcomes.  Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned.  Care plans are evaluated six monthly (refer 1.3.3.3) or more frequently as the resident's condition dictated. Interviews and documentation verified resident and family/whanau involvement. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents’ needs and desired outcomes.  Residents and family/whanau members expressed satisfaction with the care provided.  There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents’ needs. |
| Standard 1.3.7: Planned Activities  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. | FA | Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted match residents’ skills, likes, dislikes and interests, however ongoing review to verify this is not evidenced in documentation (refer criterion 1.3.3.3).  Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.  Residents’ and family meetings are held every three months. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN.  Formal care plan evaluations, following reassessment to measure the degree of a resident’s response in relation to desired outcomes and goals, occur every six months or as residents’ needs change and are carried out by the RN (refer criterion 1.2.7.5). Where progress is different from expected, the service responds by initiating changes to the service delivery plan.  A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the District Health Board (DHB). Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | The management of waste and storage and handling of chemicals policies and procedures provide clear guidelines and instructions around waste management, training, handling and storage of chemicals, the use of data safety sheets, wearing of personal protective clothing and relevant disposal requirements.  The chemical storage cupboard outside in the maintenance shed was securely locked. The maintenance person ensures all relevant supplies are kept stocked, reviewed and up to date in the cleaners’ cupboard as well as in the laundry and kitchen. The doors were secure, well labelled with appropriate signage and instructions for safe use were sighted in all storage areas. Cleaning products are all colour coded for ease of identification. The training records confirmed chemical and spill training is completed regularly as did all staff interviewed. The laundry and cleaning staff were observed and able to detail processes and procedures required for the safe use of all products for the laundry and cleaning duties.  A spill kit is stored in both the sluice room and in the civil defence and emergency supplies room.  Any incidents are reported and documented, then entered into the quality management system. Staff report they are clear about the process for incident reporting in this area. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building warrant of fitness (WOF) was sighted and expires on 1 July 2016. All electrical equipment is checked and calibrated regularly with scheduled visits by an outside contractor to complete these. Hot water temperatures are recorded monthly and any variations responded to.  The physical environment is appropriate for the needs of the residents. All mobility equipment and hoists stored in large storage areas to ensure all hallways are kept uncluttered and easily accessible for all residents. Handrails are installed in all the hallways to assist with safe mobility.  The large number of different outside areas are all easily accessed and very well maintained. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All residents’ rooms have their own bathrooms which have wet floor showers and are well maintained. There are also a number of additional toilets for residents and visitors to use in all parts of the facility. Clear labelling is used to identify these. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | The rooms are all single occupancy with a range of room sizes. All hospital level care rooms are large enough to ensure relevant mobility and hoisting aids can be used easily. The rest home rooms are all suitable for the residents, with those requiring the use of mobility aids, such as wheelchairs, being accommodated in the larger rooms. Residents were happy with their rooms and are encouraged to personalise them in whatever way they wish. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The facility has two large activity/lounge rooms provided for residents. There is another room with a large television and a computer set up for the residents to use if they wish. A small library area with lounge and reading chairs has been set up in a rest home wing. Smaller lounge areas at the end of the two wings provide additional quieter areas. A large dining room is well set up to meet the needs of all of the residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Housekeeping and linen handling and processing policies describes procedures for ensuring infection control and hygiene standards are met. The procedures for the treatment and cleaning of soiled laundry are clearly documented and clear definitions of the process for the clean and dirty areas. There are internal audit tools for laundry and cleaning services and the most recent audits were reviewed and recorded appropriate effectiveness of both services.  The laundry chemicals are all supplied by an externally contracted service who provides a monthly review and checking service. Training is given regularly to personnel involved in the laundry and cleaning. This is confirmed by relevant staff interviewed. Machines are serviced regularly and the dryer vacuumed daily to ensure no safety issues occur. All laundry is sorted into colour coded bags which separates the dirty linen, towels and personal clothing. Any soiled laundry has been through the sluice room process prior to being processed at the laundry. Personal and kitchen laundry is done in a separate machine. The process for washing linen was observed and followed the requirements.  Product data sheets are displayed in the laundry. Separate doors are provided for dirty and clean laundry with clearly marked internal areas for managing the separation.  An externally contracted service also manages the cleaning supplies which are safely stored. They provide annual training and cleaning staff interviewed confirmed this occurs.  The standard of cleanliness throughout the facility during the audit was observed as very high. Aprons, gloves and masks are provided in the sluice rooms and in all areas where personal cares are involved as well as the laundry and cleaning areas. Staff were observed using these throughout the facility as appropriate during the audit. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are policies, procedures and guidelines for emergency planning, preparation and response. Emergency and disaster planning was completed, comprehensive and current. The facility has a list of the relevant local information with telephone numbers and addresses for the civil defence centre and emergency response centres kept with the emergency “grab bag” which also includes a list of all current residents. There are five large water storage tanks located around the site and fire hoses are available in each fire cell area. Evacuation plans and assembly points are displayed around the facility. A well-stocked civil defence cupboard is checked monthly to ensure currency and the onsite emergency generator is also checked on a monthly basis. An outside gas bar-b-que can also be used if required. Adequate food is stored that would be used in the event of any emergency.  Fire evacuation drills are held at least six monthly with the last one held in April 2016. These are managed by an external contractor and no issues were noted. All staff attend these. The approved evacuation plan was sighted with approval dated of 1997. Education for emergency responses and evacuations are held regularly and as a part of the orientation programme for all staff.  The electronic call system displays the relevant room number in lights in a number of areas around the facility to alert staff as to which resident is requiring attention. During the audit bells were observed to be answered very quickly.  The quality committee bi-monthly meetings discuss any safety incidents reported and also they ensure hazards are eliminated or controlled across the facility. Staff ensure the facility is locked and secure each evening and the manager reported there have been no reports of any concerns with security. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Most individual rooms open out through large sliding doors onto gardens or patio areas. Communal areas also have opening external windows with some also having doors that open onto outside areas. The entire facility is heated by heat pumps with each room having its own heat pump which they can control to suit individual preferences.  All areas are well lit and ventilated and temperatures during the audit were comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection prevention and control policy reflects the requirements of the infection prevention and control standard (NZS 8134.3:2008). The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. The infection control programme, reviewed annually, establishes, maintains and monitors procedures covering infection control practices.  The infection control practices are guided by the infection control manual, with assistance from an external infection control advisor.  It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted at audit. Reporting lines are clearly defined. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control nurse (ICN) is responsible for implementing the infection control programme and reports directly to the facility manager. A position description is included in the infection control (IC) programme.  The infection control committee meets every two months as part of the quality meeting.  The ICN and observation verified there are enough human, physical and information resources to implement the infection control programme. Training records sighted and interview with the ICN verifies that the ICN attends regular ongoing training. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control programme includes policies and procedures. Policies are current and reflect accepted best practice and relevant legislative requirements.  Staff interviewed verified knowledge of infection control policies. Staffs were observed to be compliant with generalised infection control practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verify staff have received education in infection control and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation.  Resident education occurs in a manner that recognises and meets the residents’ and the families’ communication style, as confirmed in resident and family interviews. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | In line with Health and Disability Services Standards (HDSS), Infection prevention and control standard (IC) (NZS 8134.3:2008), surveillance of infections is occurring as per the HDSS IC surveillance guide, and is the responsibility of the infection prevention and control nurse.  Incidents of infections and the required management plan are presented daily at handover, to ensure early interventions. Surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions.  Incidents of infections are presented at the quality meetings and any ongoing corrective actions discussed and presented to staff at staff meetings, as evidenced by meeting records, infection control records and staff interviews. Incidents of infections are benchmarked by an external provider. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Bethsaida has a comprehensive suite of policies and procedures which meet the requirements of the restraint minimisation and safe practice standards with appropriate definitions provided. The restraint coordinator, who experience in this area, provides support and oversight to the restraint management processes of the facility. In interview she demonstrated a sound understanding of the organisation’s policies and procedures.  The policies and procedures emphasise that the use of restraint is a last resort and all alternatives are explored before restraints are used. This was also evident on review of records of those residents who have approved restraints and enablers. The use of restraints is minimised as much as possible while still maintaining safety.  On the days of audit there were two residents using enablers. In both cases the residents have requested the equipment, a sensor mat and a bedside rail. A similar process to that followed for the use of restraints is used for enablers that ensures the on-going safety and wellbeing of the resident. In all cases the resident is voluntarily using the equipment and it was included in their care plan. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | There is a restraint approval process and a restraint approval group which has been set up to have oversight for restraint processes and procedures. The group is made up of staff from both nursing and care giving staff and the facility manager. The group currently meets every two months. The resident’s general practitioner is also a part of any approval and review process at least three monthly, or as required.  Restraints are used for safety only. Records were reviewed and confirmed the organisation’s required processes are implemented with the approval process being followed.  On the days of audit there were three residents with approved restraints (lap belts and leg harnesses). The restraint register, meeting minutes and records on residents’ files demonstrated that the restraint coordinator is performing the role competently. It is recommended that a specific position description be developed to formally describe the role.  Residents who have approved restraints have the appropriate approval documentation on their files. Their care plans include reference to the current approved restraints in use. There is also evidence of family/whanau/EPOA involved in the decision making as is required by the organisation’s policies and procedures. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The assessment process includes all requirements of this standard. The initial assessment is undertaken by the clinical team with input from the resident’s family/whanau/EPOA. The general practitioner is always involved in the final decision on the safety of the use of the restraint.  The assessment process includes consent from the resident’s family/whanau or EPOA, whoever is most appropriate. All residents using restraints at the time of the audit have a current assessment and consent form. Alternative strategies have been discussed and behaviour patterns monitored. Any historical information and comments from any other referrers are included in the assessment process, as are any relevant cultural considerations. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The use of restraints is actively minimised. At interview with the restraint coordinator, she described how alternatives to restraints are discussed with family/whanau when they request restraints. Time is spent explaining how the resident can be safely supported and alternatives explored before use of a restraint is implemented.  A restraint register is maintained by the restraint coordinator. It is updated and discussed at the quality group meetings. The register for all the current residents was reviewed. The register has been maintained with all relevant information recorded. Changes on the register reflect any changes in need that are identified.  Staff members interviewed reported that restraints are used as a last resort and only to ensure safety. They receive training in the organisation’s policy and procedures and in related topics such as supporting people with challenging behaviours in positive ways. Their understanding is that the use of restraints is to be minimised as much as possible. They also confirmed they understand the need to complete all monitoring documentation as required. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint coordinator reported that evaluation of the use of restraints for every resident is done on an on-going basis. This includes regular review and updating of the documentation relating the use of the restraint and feedback from staff members involved in the providing care and support to each resident. Any changes since the last review are considered with the possibility of removing the restraint discussed for each person and carefully considered. This does occur if the need is no longer identified.  All requirements of this standard are included in the evaluation of restraint use and are documented on each resident’s file. This was confirmed on review of files during this audit.  When restraints are in use they are monitored and documented frequently to ensure the resident remains safe. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The manager and relevant clinical team undertake a three monthly review of all restraint use which includes the requirements of this standard. Additional information is included in the quality committee minutes meeting which has benchmarked data and graphs of restraint use over time with other external facilities and externally received on a monthly basis.  Although the current number of restraints in use is relatively low, the restraint coordinator is committed to looking at ways to reduce the use of restraint across the facility. Interviews with staff members confirmed their understanding of a focus on safety, wellbeing and reducing the use of restraints as much as practicable. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Negligible | The facility has three interRAI trained registered nurses with one awaiting training. However there are no available places for the training being provided by the agency responsible, until September of this year. The recent resignation of a trained assessor has meant the workload for the remaining assessors is unmanageable resulting in a number of assessments that are yet to be completed and reviewed. The provider has ensured all other assessments of residents have been completed so there is negligible risk to any residents. | Some residents admitted since July 2015 have not had interRAI assessments completed or reviewed as per the contractual requirements. This is in part due to the resignation of two trained interRAI assessors which the provider has taken steps to replace, as well as the scheduling of training for new staff, which is beyond the control of the provider, and has led to a delay in carrying out these assessments. | As soon as training is able to be accessed, support the RN to attend.  365 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | In files reviewed, activity plans had not been reviewed or updated to ensure residents are provided with appropriate activity services to meet their desired needs and outcomes. This has been recognised by the service and a documented plan is in place to address this finding. | Residents’ activity plans are not reviewed every six months or as resident’s needs change. | Activity plans are reviewed every six months or as residents’ need change to ensure residents receive the required services to meet their assessed needs or desired outcomes.  180 days |

# 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, these 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.