Metlifecare Limited - Powley

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 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.

The specifics of this audit included:

Legal entity:	Metlifecare Limited
Premises audited:	Metlifecare Powley
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 January 2017 End date: 24 January 2017

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: 41

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Metlifecare Powley is one of 24 facilities owned and operated by the Metlifecare group, eight of which have care facilities. Metlifecare Powley provides rest home and hospital level care for up to 45 residents. There is a village on the same site; this was not subject to this audit.

This surveillance 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, a review of staff files, observations, and interviews with residents, a family member, management, staff and a general practitioner. Feedback from residents and families/whānau members was positive about the care and services provided.

The four areas requiring improvements from the previous audit have been addressed by the service and are now fully attained. There are two new areas identified for improvement from this audit related to staff education, and the food fridge temperatures.

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.

The service demonstrates that residents' rights to full and frank information and open disclosure principles are met. Interpreter services are used wherever necessary to ensure good lines of communication are maintained.

Complaints management is well documented. All processes are undertaken to meet standard requirements. There are no open complaints at the time of audit.

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.

Metlifecare Limited's governing body ensures that business and strategic planning is in place to cover all aspects of service delivery. Metlifecare Powley's business plan is personalised to the services offered to ensure residents' needs are met. Quarterly reporting of the facility's goals is undertaken to head office. The village manager is responsible for the overall management of the facility and the nurse manager, who is a registered nurse, oversees all clinical aspects of care.

At facility level, the quality and risk system and processes support effective, timely service delivery. Corrective action planning is implemented to manage any areas of concern or deficits. The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident surveys, restraint and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and family/whānau, as appropriate. Exception reporting is monitored by the clinical governance group which operates at Metlifecare governance level.

Human resources management policy reflects good current practice and meets legislative requirements. The service implements the documented staffing levels and skill mix to ensure contractual requirements are met.

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 low risk.

Services are provided by suitably qualified and trained staff to meet the needs of residents. The registered nurses are supported by care and allied health staff including, a podiatrist, physiotherapist, pharmacists, occupational therapist and general medical practitioners. Shift handovers support continuity of care.

Residents have an initial nursing assessment and care plan developed by a registered nurse (RN) on admission to the service. All residents` records reviewed demonstrated that individual needs are identified, and care provided to meet these needs with the resident and family's input.

Residents and families interviewed reported being well informed and involved in the care planning process, and that the care provided is of a high standard.

The planned activity programme provides residents with an appropriate variety of individual and group activities.

Medicines are managed according to policies and procedures based on current good practice, and consistently implemented using an electronic system. Medicines are administered by registered nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. The service has a four-week rotating menu which is approved by a registered dietitian. Residents verified satisfaction with meals.

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.

The facility has a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. At the time of audit there are four enablers in use and no restraints.

Infection prevention and control

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

Aged care specific surveillance is undertaken, analysed and results reported and communicated to staff at the staff meetings, and compared with other similar facilities. Follow-up action is taken when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	0	0	0
Criteria	0	37	0	2	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.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Metlifecare Powley implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system. All complaints are registered at Metlifecare head office electronically (V-care). Residents, family/whānau and staff reported during interview that they understand the complaints processes in place and are aware of where to find written complaints forms. The electronic complaints register sighted identifies that at the time of audit there are no open complaints. All complaints have been resolved at facility level since the previous audit. Documented complaints information is used to improve services as appropriate. One example relates to the length of time taken to respond to a call bell. Following appropriate corrective actions being put in place, which included 'tool box' education for staff, the average length of response time taken over 1 week for the client reduced from 12.43 minutes to four minutes. Complaints are a standing agenda item for both management and staff meetings as confirmed in meeting minutes sighted. There have been no coroners' inquiries, district health board investigations or Health and Disability Commissioner complaints since the previous audit.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The open disclosure policy is based on the principles of full and frank information sharing with residents and their family/whanau. This is confirmed during resident and family/whanau interviews. Evidence of open disclosure was seen in residents' progress notes and identified on incident and accident forms. Management and staff confirmed that interpreter services are available if required. Residents confirmed that communication between themselves and staff is open and honest.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The organisation's philosophy, mission statement and values are clearly documented. As required to meet policy, Metlifecare Powley has a personalised business plan which is in line with the goals and objectives of the organising body. Metlifecare Powley's business plan identifies how services are planned to address residents' needs and documented goals are reported against to head office quarterly. On the days of audit there were 41 beds occupied. These consist of seven rest home level care and 34 hospital level care residents. The management team consists of the village manager and the nurse manager who holds and annual practising certificate. Both managers have been in their roles for many years and have experience and qualifications related to their roles. They are assisted by a senior registered nurse who has been in the role eight years. They maintain appropriate education to keep their skills and knowledge up to date. The nurse manager is responsible for services and care delivery within the care unit. Interviews with residents and family/whānau confirmed that their needs were met by the service. The 2016 resident satisfaction survey results indicate an overall satisfaction rating of 81%. No negative comments were received on the days of audit.
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	The service has a quality and risk management system which was understood and implemented by service providers. This includes the development and update of policies and procedures at organisational level, regular internal audits, incident and accident reporting, health and safety reporting, restraint, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Corrective actions are evaluated prior to being closed off by the nurse manager. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. Quality data collected is analysed at facility and at governance level. Results are trended and benchmarked against previously collected data and the other Metlifecare care facilities. Metlifecare Powley use the quality information collected to inform ongoing planning of services to ensure residents' needs are met. Infection control data is also benchmarked off-site against other like facilities throughout New Zealand. At

		organisational level, quality processes are overseen by the clinical quality and risk manager and the clinical nurse director. Actual and potential risks are identified and documented in the hazard register and in the quality and risk plan. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes which are taken to the health and safety meeting. There is also an up to date hazardous substance register. Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management.
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	Adverse event reporting as identified in policy is implemented by the service. The nurse manager and senior registered nurse confirmed their awareness of the organisation's requirement related to statutory and or/regulatory reporting obligations including pressure injury reporting. Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. Follow up actions are clearly documented. This is confirmed in the incident and accident forms sighted. Interviews and documentation sighted confirmed family/whānau are notified of any adverse events or concerns staff have about residents. Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated.
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 Low	Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. The employment process is overseen by head office and this is recorded electronically and on paper. All roles have job descriptions that describe staff responsibilities. Staff complete an orientation programme with specific competencies for their roles. Documentation in the staff files reviewed confirmed some competencies, such as medication management, are repeated annually. Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. The education calendar sighted identifies that staff are offered training and education related to their roles. Topics covered in annual training and education relates to age care and health care services. Members of the management team also attend workshops and seminars specific to management related topics. Education occurs both on and off site. Not all educational requirements could be verified on the day of audit.

		The ethnicity and language skills of staff match those of the residents at the facility. Resident and the family member interviewed, identified that residents' needs are met by the service. No negative comments were voiced during interviews on the day of audit.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Policy identifies staffing levels and skill mix are maintained via the use of a 'staffing level planning tool' to meet residents' needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified and experienced staff are on duty to provide safe quality care. Rosters are analysed at head office to ensure staffing numbers match residents' level of care needs. All shifts are covered by a registered nurse and at least one staff member who holds a current first aid certificate. A review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents interviewed stated all their needs have been met. The nurse manager works Monday to Friday and they have administration assistance. The activities coordinator works Monday to Friday and there are dedicated laundry and cleaning staff seven days a week. There is availability for one member of the night care team 7 nights a week from 10.45pm to 7.15am to respond to any village call bells to ensure there are always a minimum of 2 staff on the floor in the care unit. The kitchen staff are managed as part of the village.
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 and procedure clearly describes the processes to ensure safe administration of all medications. The facility has changed to an electronic medicine management system since the last audit (early 2016). The GP interviewed confirms prescribing is easier and can be done remotely when required. Nursing staff interviewed like using the new system. A review of resident's medicines by the GP occurs at least three monthly. Medicines for residents are received from the pharmacy in a pre-packed delivery system and are checked on arrival. Safe medicine management was observed during the audit. Residents are informed of the names of each medicine being administered and the expected action. The resident has the right to refuse offered medicines, and in this event the rational is noted. Long term or short term changes in medicines prescribed are discussed with the resident or their family as was observed and verbalised by residents and family interviewed. Medicines are locked away in two secure rooms. Two medication trolleys are used for the medication round. Controlled drugs are managed in accordance with legislative requirements.

		Resident photo identification is on all individual resident's records reviewed. Allergies and sensitivities are noted. Short course medicines are clearly identified. Medicine reconciliation is sighted in the sampled residents' files. Two residents were observed self-administering medications. There is a three monthly risk assessment for all residents who have been approved by the GP and the registered nurse to administer their own medications. Medicines were observed to be stored securely in a locked box in the bed room of one of the residents audited using tracer methodology. There are documented competencies for nursing staff and the limited number of care staff who check controlled drugs when there is only one RN on duty. The shortfall from the last audit has been addressed.
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.	PA Low	The food service is provided on site by employed staff. The kitchen manager has extensive relevant experience and has worked in this facility since October 2016. The kitchen manager is assisted by nine kitchen staff. Seven staff have completed food safety training. The menu is a four week seasonal rotating menu. The current menu has been reviewed by a qualified dietitian. A nutritional assessment is undertaken for each resident on admission to the facility by the registered nurse and a dietary profile is developed and regularly reviewed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident`s nutritional needs, is available. Nutritional supplements are also readily available and used. Resident satisfaction with meals is verified by resident and family interviews. The main meal is provided midday. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner. There is sufficient staff on duty in the dining room at meal times to ensure appropriate assistance is available to residents as needed. Where preferred, residents can eat their meals in their room and staff assistance is also provided as required. Aspects of food services align with required standards, with the exception of the temperature range for one of the refrigerators.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. This includes where short term care plans have been developed for short term or new events that were not included of the long term care plan. Interventions were provided to the sampled residents for wound care, pressure area / injury management,

order to meet their assessed needs and desired outcomes.		confusion, pain, weight loss, monitoring a resident after a fall, treatment of infections and care post discharge from the DHB following surgery. The shortfall from the last audit has been addressed. The service has adequate wound care and continence supplies to meet the needs of the residents. Observations on the day of audit indicated residents are receiving appropriate care to meet their individual needs. The nursing team discussed the care plans which are comprehensive. The caregivers interviewed reported that the care plans are able to be followed
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	The activities programme is developed and implemented by the activities coordinator who has been in the role since April 2016. The activities plan is provided in advance to all residents. Daily records of attendance are maintained. A social assessment and history is undertaken on admission to ascertain residents` needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident`s activity needs are evaluated at least six monthly as part of the six monthly care plan review and the annual multi-disciplinary review. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. The activities reflect residents` goals, ordinary patterns of life and includes normal community activities, individual group activities and one on one activity as needed. Examples included music /entertainment sessions, bingo, baking, arts and crafts, gardening, exercise, outings, and special events. Participation in any activity is voluntary. There are church services occurring onsite for consenting residents. There is also a chapel and library on site. Most activities are scheduled Monday to Friday; however, a movie and ice cream is scheduled for Saturdays. The shortfall from the last audit has been addressed. Residents interviewed confirmed they were satisfied with the programme and their participation is encouraged but not forced.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The residents` records reviewed had a documented evaluation that is conducted within the past six months for residents. Evaluations are resident focused and indicate the degree of achievement or response to support interventions and progress towards meeting the desired outcomes / goals. If a resident is not responding to the interventions being delivered, or their health status changes, then this is discussed with the GP and family. Residents` changing needs are clearly described in the care plans reviewed. Wound assessments were documented on template forms and regularly reviewed (including daily when required). Bowel charts were maintained and used a recognised stool assessment tool. Short term care plans are used for wound care, changes in food and fluid intake and skin care and/or

		pressure area care when needed and in the event of an infection. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that these are communicated during handover. Fluid balance charts are used when required to monitor a resident's fluid intake, and a turning chart to verify when pressure relieving strategies were implemented for the resident with a pressure injury. A multidisciplinary meeting is scheduled annually and the resident and / or next of kin are invited.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 13 June 2017. There have been no changes to the building footprint since the previous audit.
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	Surveillance is appropriate to that recommended for a long term care facility. This includes urinary tract infections, skin / wound infections, eye infections, chest infections, multi drug resistant organisms (MDRO), gastroenteritis and other infections. When an infection is identified, a record of this is documented on the infection reporting form, and also detailed in the resident's clinical record. The infection prevention and control coordinator reviews all reported infections and details the name of the resident, the type of infection, the results of laboratory investigations (if applicable), the treatment and the outcome. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are communicated at the time an infection is identified via discussion during shift handover and discussed at the monthly staff meeting. Infection rates are benchmarked with other aged care facilities.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. It states that the service aims to minimise the use of restraint and to ensure that if restraint is necessary, to keep the resident safe from harm. The use of enablers is voluntary and the least restrictive option to meet the needs of the resident. Policy contains all necessary documentation related to the use of restraint. The service had no restraints and four bedside rail enablers in use at the time of audit. Clinical staff undertake an annual competency and education related to the safe and correct use of restraint should it be required. Staff verbalised their understanding and knowledge related to restraint and enabler use during

		interview.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The service undertakes education as shown on their annual educational plan. It covers all aspects of service delivery. Staff education information is included in staff personnel files. However, of the six files reviewed one cleaner, who has been employed for over 12 months, has not undertaken safe chemical handling education therefore policy requirements are not met. The nurse manager operates an electronic spreadsheet to show staff attendance at education sessions but this has not been kept up to date and could not be used to verify what education staff had completed. Two registered nurses undertake interRAI assessments but their competencies could not be verified as no record was located in their staff file and neither staff member was rostered the day of audit.	One member of the cleaning staff has not undertaken safe chemical handling; the staff education spreadsheet has not been kept up to date; competencies for the two staff who undertake interRAI assessments were not sighted.	Provide documented evidence that staff education is up to date according to the roles they undertake and to meet policy requirements. 180 days

Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	All aspects of production, preparation, storage and disposal comply with current legislation and guidelines with one exception. The temperature of the under bench fridge has been documented as above the required temperature range (2-8 degrees Celsius) on seven occasions since 9 January 2017, with no identifiable action taken. The kitchen manager had not been informed of this issue. The refrigerator temperature when checked during audit was 13.7 degrees C. A new food safety plan has been recently developed and is reported by the kitchen manager to have undergone initial review by Auckland City Council.	The temperature of the below bench refrigerator is regularly above the maximum accepted range.	Ensure refrigerated food items are maintained between 2-8 degrees Celsius. 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.

No data to display

End of the report.