# Sunflower Field Trading NZ Limited - Summerville Rest Home

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Sunflower Field Trading NZ Limited

**Premises audited:** Summerville Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 25 October 2017 End date: 25 October 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:** 11

# 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

Summerville Rest Home provides rest home level care for up to 15 residents. On the day of the audit there were 11 residents. The owner/managing director manages the business remotely and is supported by the manager. The service is overseen by the manager who has been in the role for 26 years. The manager has worked in the health care and aged care sectors for a vast number of years. She is supported by a registered nurse who works 12 hours a week. The service has an annual business/quality plan for 2017 in place.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident’s and staff files, observations and interviews with residents, staff and management.

The service has addressed all eight previous certification findings around: policy reviews, documented business/quality plan, staff employment documentation, care planning, activities plans, wound care documentation, and medication management and administration.

This surveillance audit identified an improvement required around adverse event reporting.

## 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. |

Information about services provided is readily available to residents and families/whānau. Residents and family are well informed including of changes in residents’ health. The manager promotes an open-door policy. Complaints processes are implemented, and complaints and concerns are managed and documented.

## 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. |

Summerville Rest Home has a quality and risk management system. Key components of the quality management system link to the staff/quality meetings. An annual resident/relative satisfaction survey is completed and there are monthly resident meetings. There are human resource policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. Annual staff performance appraisals are in place. There is an in-service training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

## 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. |  | Standards applicable to this service fully attained. |

Residents are assessed on entry to the service by the registered nurse. There are entry and admission procedures in place which include interRAI assessments. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate, Care plans are evaluated six monthly or more frequently when clinically indicated. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the contracted general practitioner and visiting allied health professionals. The activities coordinator provides an activities programme for the residents that is varied, interesting and involves the families/whānau and community. Medication policies comply with legislative requirements and guidelines. Staff responsible for administration of medicines completes education and annual medication competencies. All meals are prepared on-site. There is a menu in place which is reviewed by a dietitian. Food, fridge and freezer temperatures are recorded. Residents' food preferences are accommodated and the residents report satisfaction with the food service.

## 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. |

There is a current building warrant of fitness.

## 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. |

Summerville Rest Home has a restraint-free philosophy. There were no residents on restraint or using enablers. Staff education on restraint minimisation and management of challenging behaviour has been provided.

## 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 infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

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

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| **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 | 16 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 1 | 0 | 0 | 0 |

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| **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).

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| **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 | The service has a complaints policy that describes the management of complaints process. There is a complaint register and complaint forms are available in the service entrance. Information about complaints is provided on admission. Discussions with four staff (two caregivers, one activities coordinator and one house keeper) stated that concerns/complaints were discussed at bi-monthly staff/quality meetings and this was verified in meeting minutes reviewed. Interview with all five residents confirms an understanding of the complaints process. Two complaints have been made since the last audit. The complaints reviewed were managed appropriately with acknowledgement, investigations and responses recorded. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The manager promotes an open-door policy. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. Communication with family members is recorded on the incident report forms and in the resident daily progress notes. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. However, not all forms had notification to the next of kin (link 1.2.4.3). Five residents interviewed confirmed that the staff and management are approachable and available. There were no relatives that visited on the day of the audit. Staff were observed communicating effectively with residents. The information pack is available in large print and advised that this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Summerville Rest Home provides rest home level care for up to 15 residents. On the day of the audit there were 11 residents, including one resident on respite and one resident on a mental health contract. All other residents were on the age related residential care (ARRC) agreement.  Summerville Rest Home is owned by a non-New Zealand registered medical practitioner. He assumes the role of managing director only. The managing director manages the business remotely and is supported by the manager. The service is overseen by the manager who has been in the role for 26 years. She has a certificate in management. The manager has worked in the healthcare and aged care sectors for a vast number of years. She is supported by a RN who works 12 hours a week. On the day of the audit the RN was absent. The service has an annual business/quality plan for 2017 in place, including annual goals, action plans, responsibilities and date/timeframes.  The manager has maintained eight hours of professional development in the past 12 months. |
| 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 | Summerville Rest Home has a quality and risk management system that supports the provision of clinical care and support. The bi-monthly staff/quality meetings include discussion around, internal audit outcomes, health and safety, infection control, incident/accidents, complaints and restraint as needed. The minutes of these meetings are documented. The service has resident meetings once a month with the activities coordinator. The activities coordinator documents any concerns on a form to take to the next meeting. There are a range of policies, associated procedures and forms in place. Policies were reviewed in February 2017 to meet the requirements of the relevant Health and Disability Services Standards 2008 (policies were sighted). The service has a 2017 business/quality plan in place. Progress toward previous goals has been monitored regularly. The previous findings around policy reviews and documented business/quality plan have now been addressed.  An annual satisfaction survey is conducted to encourage resident and family feedback. The 2017 resident and family satisfaction surveys have been completed and reported back to staff/quality and resident meetings with evidence of changes made as a result of survey feedback. There is a wall planner with a schedule of internal audits. Corrective action format is used for audits, meeting minutes and reports. The service reviews all audits six-monthly and action plans are followed up through staff/quality meetings. There is a Health and Safety and risk management system in place including policies to guide practice. There is a current hazard register, which was last reviewed in October 2016 and was due to be reviewed later in the week of the audit. Hazards are documented on the register and have interventions documented to manage the risk. Falls prevention strategies are in place, which include the identification of interventions on a case-by-case basis to minimise future falls. |
| 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. | PA Low | The service collects incident and accident information. Incident/accident data is reported and monitored though staff/quality meetings. Incidents and accidents are reported, and the immediate and appropriate clinical actions taken are documented in incident forms. Twelve accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a RN. However not all forms had notification to the next of kin and not all neurological observations were completed for resident falls that resulted in a potential head injury. |
| 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. | FA | There are 13 staff employed by Summerville Rest Home which includes a manager, a RN, caregivers, cleaner, kitchen staff and an activities coordinator. The practising certificate for the RN is current. The service maintains copies of the other visiting practitioner’s certification. Five staff files reviewed including one manager, two caregivers, one RN and one activities coordinator contained all relevant employment documentation, including signed job descriptions, employment agreements and orientation checklists. The previous finding around staff employment documentation has been addressed. There is an annual appraisal process in place and performance appraisals are current in the five files reviewed.  New staff complete an orientation checklist that was sighted in all five staff files reviewed. The service has a 2017 training schedule for in-service education. Attendance is recorded at sessions and each session includes an attendance sheet. Interview with caregivers indicated there is access to sufficient training. Medication competencies are completed for all staff who administer medication. First aid/CPR training is provided for all care staff. The RN and the manager have both completed interRAI training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a policy on staff numbers and skills required. Skill mix is reviewed on a regular basis and reviewed in-line with resident numbers. The manager is on-site from 8.00am until 4.00pm Monday to Friday and is on-call 24/7 for any operational issues. There is a RN on-site for 12 hours per week or more if required and is also on-call 24/7 for any clinical concerns. The local general practitioner (GP) also provides after hours care if required and caregivers have access to the local ambulance service. There are two caregivers on duty on the morning shift, one caregiver on duty on the afternoon shift and one caregiver on the night shift. There is an additional caregiver who covers the ‘tea’ shift from 5.00pm to 8.00pm. Roster shortages or sickness are covered by casual or off duty staff. The caregivers and residents interviewed report that there is sufficient staff cover. |
| 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 | There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses a four-weekly blister pack system for tablets and other medicines are pharmacy packaged. A verification check is completed by the RN against the resident’s medicine order when new medicines are supplied from the pharmacy. All medicines are stored securely when not in use. Short-life medications (i.e., eye drops and ointments) are dated once opened. Ten medication charts reviewed identified that the GP had seen and reviewed the resident’s medications three-monthly. All medication charts sampled met legislative prescribing requirements. Medication orders include indications for use of ‘as needed’ medicines.  Staff were observed to be safely administering medications. All medication administered was documented on the medication signing sheets each time a medicine was administered by staff. Staff (senior caregivers) interviewed were aware of their responsibilities regarding medicine administration and the need to seek RN advice if required. One medication chart was reviewed for a resident on oxygen. Oxygen was noted to be charted. The previous findings related to prescribing of medications given and incorrect medication administration have been addressed. There were no residents self-medicating at time of audit. There were no standing orders. Residents interviewed stated they are kept well informed of any changes to their medications. |
| 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 | All meals at Summerville Rest Home are prepared and cooked on-site by the caregivers who are assigned to cooking duties on the roster. The baking and some food preparation is done by the night staff. Care staff have completed safe food handling and chemical safety training. There is a four-weekly menu in use that has been reviewed by a dietitian annually. The main meal is at midday. All meals are delivered straight to the dining room. A tray service is available if required. Resident likes, and dislikes are documented (form completed on admission) and known to the caregivers. Cultural and religious food preferences are met. Alternatives are offered. Special diets are accommodated.  Supplements and high calorie diets are provided to residents with identified weight loss issues if required. Lipped plates and smaller serving plates are available to promote independence at meal times. The kitchen is well equipped with gas hobs, electric oven, freezers, one fridge/freezer and dishwasher. All perishable goods are date labelled. Fridge/freezer temperature monitoring and hot food temperature monitoring is maintained daily. Food that was stored in the fridge was dated and labelled. Chemicals are stored in a lockable cupboard. Food is procured from local commercial suppliers and the supermarket. Residents spoke positively about the meals and home baking. Resident meetings provide an opportunity for resident feedback on the meals. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The care plans reviewed were individualised and reflected care interventions required to meet the resident’s assessed needs. The previous audit identified that not all care plans had all interventions for care requirements related to behaviour management documented. Two long-term resident files reviewed with assessed behavioural challenges had all interventions included( but not limited to); triggers, de-escalation and distraction techniques documented to manage behaviour. The previous audit finding related to documented behavioural interventions has been resolved. The care staff interviewed were knowledgeable regarding individual resident needs. There were short-term care plans in use for short-term needs and changes in health status. There is documented evidence of resident/family input into care planning and six-monthly reviews. Care plans included involvement of allied health professionals in the care of the resident. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the RN initiates a review and if required, GP (or nurse specialist consultation). The manager (when on-call or when RN not available) refers to the GP as required. Residents interviewed reported their needs were being met. The resident files reviewed confirmed families are notified of any changes to their relative’s health condition. In the residents’ files reviewed, short-term care plans were commenced with a change in heath condition and linked to the long-term care plan. Long-term care plans were reviewed six-monthly. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.  The manager was able to describe access for wound and continence specialist input as required. Caregivers and manager (interviewed) state there is adequate continence and wound care supplies. Documentation was reviewed for one chronic wound. There were no pressure injuries. The evaluation of wounds was well documented. Photos are taken, and staff could describe how the wound is measured for progress. The previous audit finding related to evaluation of wounds has been resolved. Monitoring charts were in use and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid and behaviour monitoring as required. |
| 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 | There is one activities coordinator employed (a non-practicing RN), who is responsible for the planning and delivery of the individual and group activities programme with assistance from staff. The activities coordinator is employed ten hours (over three days) a week. Caregivers assist with individual and group activities programmes at other times during the week and at weekends. Individual activities assessments, social assessments and an individual activities programme are developed by the activities coordinator shortly after admission. The activities plan reflects the assessed resident’s needs. The previous audit finding related to activities plans has been resolved. The individual activities plan is reviewed six monthly when the resident’s care is reviewed. The residents interviewed report the group programme meets their needs and participation is voluntary. The activities programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. The programme includes craft, entertainers, games, housie, quizzes, piano sing-a-long sessions and pet therapy. There is a resident cat.  Two residents attend groups in the local community. On the day of audit residents were observed participating in a variety of activities. One-on-one activities are provided for residents who are unable or choose not to be involved in group activities. Residents have the opportunity to provide feedback and suggestions for future activities, celebrations and entertainment. The programme is flexible and accommodates community visitors and groups. Residents are supported to attend their own church and are transported by families. The activities coordinator is responsible for the resident’s individual activities plans which are developed within the first three weeks of admission. The resident/family/whānau, as appropriate, are involved in the development of the activity plan. A daily record is kept of individual resident’s activities and a monthly activities assessment is completed. A six-monthly review is completed with the care review. Residents interviewed report satisfaction with the activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the files reviewed, initial care plans were evaluated by the RN within three weeks of admission. The long-term care plans were evaluated at least six monthly or earlier if there is a change in health condition. There was at least a three-monthly review by the GP. All changes in health status were documented and followed up. Short-term care plans were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| 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 holds a current warrant of fitness, which expires 17 January 2018. |
| 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 | Policies and procedures document infection prevention and control surveillance methods. Systems are in place and are appropriate to the size and complexity of the service. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. The infection control coordinator (RN) collects the infection rates each month, identifies trends and uses the information to initiate quality activities including training needs. Infection control internal audits have been completed (last March 2017 with no corrective actions required). Care staff interviewed are aware of infection rates. Infection rates have been low. There have been no outbreaks since previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a policy in place around restraint. Summerville Rest Home has a restraint free philosophy. On the day of the audit there were no reported events of either restraint of enabler use. Staff education on restraint minimisation and management of challenging behaviour has been provided. |

# 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 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | The service collects incident and accident information. Incidents and accidents are reported, and the immediate and appropriate clinical actions taken are documented in incident forms. Twelve accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a RN. However, not all forms had notification to the next of kin and not all neurological observations were completed for resident falls that resulted in a potential head injury. | Twelve incident/accident forms were reviewed in total. Ten of twelve incident/accident forms reviewed did not have documented evidence of notification to the next of kin. Three incident/accident forms reviewed were for unwitnessed resident falls with a head injury. There was no documented evidence of neurological observations forms being completed. | Ensure that next of kin are notified of any incident and that neurological observations forms are completed for any resident fall with a head injury.  90 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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| No data to display |

End of the report.