

# Clare House Care Limited - Clare House

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## 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](#).

The specifics of this audit included:

<b>Legal entity:</b>	Clare House Care Limited
<b>Premises audited:</b>	Clare House
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 24 July 2018    End date: 25 July 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	63

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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

Clare House provides rest home, dementia and hospital level care for up to 87 residents. The service is operated by a private company and managed by a general manager and a clinical care manager. Both managers are new to the service since the previous audit. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, contracted allied health providers and a general practitioner.

This audit has identified that improvements are required relating to analysis of adverse events and storage of oxygen cylinders.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff were observed treating residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility. The clinical manager has recently resigned, but recruitment is underway to fill the position when she leaves in three weeks.

The quality and risk management systems include collection of quality improvement data. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance reviews. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## 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.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family. Visits to the facility are welcomed.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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The organisation has implemented policies and procedures that support the minimisation of restraint. Six enablers and seven restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and 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)
<b>Standards</b>	0	48	0	2	0	0	0
<b>Criteria</b>	0	99	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Clare House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed could give examples of the rights and how they apply them in day to day care (eg, knocking before entering a resident's room (respect). Staff were observed closing doors when commencing cares (privacy). Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. Staff attended training on residents' rights on 16 October 2017, attendance records were sighted. An internal audit occurred on 5 June 2018 which verified the residents' rights were incorporated in daily care.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form for such things as 'flu' vaccine. Advance care planning was not present in any of the 12 files reviewed but information was available in the family room for discussion if required. Establishing and documenting Enduring Power of Attorney (EPOA) requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care. All residents in the dementia services have an EPOA enacted in</p>

		files reviewed.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents/family members are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family/whānau members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by maintaining use of their general practitioner in the community. Residents also attend a variety of organised groups such as the stroke club, community craft groups as well as organised visits, shopping trips, activities, and entertainment, as sighted on the activities calendar.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family/whānau members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that five complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans show any required follow up and improvements have been made where possible. The general manager (GM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There has been one complaint received from the Health and Disability Commissioner since the previous audit. This was received on the second day of this audit.</p>
Standard 1.1.2: Consumer Rights	FA	Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided,

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>discussion with staff and by written information. The Code is displayed in the main foyer together with information on advocacy services, how to make a complaint and feedback forms. Posters are also displayed in each wing. Opportunities are provided for explanations, discussion, and clarification about the Code with the resident, family/whānau, where appropriate, and/or their legal representative, during contact with the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed during interview that they/their relative receives services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit by closing doors to bedrooms. All residents have a private room, decorated with personal mementoes and furniture.</p> <p>Residents are encouraged to maintain their independence by arranging their own visits to the doctor, participation in clubs of their choosing and outings with family/whānau, for example. Care plans included documentation related to the resident's abilities, and strategies to maximise independence, personalised for each resident.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified on admission, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and then annually. A training session on this topic was held last on 6 October 2017, as verified in attendance records sighted.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>There was one resident in the rest home who identified as Māori. On interview the resident confirmed satisfaction with the way respect was shown and individual needs were met. He reported being happy that his culture, values and beliefs were recognised and respected. He reported no discrimination. Family and residents were involved in the admission process and in developing the care plan.</p> <p>The Māori health plan supports a holistic approach when considering Māori wellbeing as reflected in the Whare Tapa Whā model. Advice was able to be sought from appropriate cultural advisors.</p> <p>Cultural awareness training occurred in October 2017 and is part of the orientation programme for staff.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs on admission and that this information was used to form the basis of the care plan. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. A letter of compliment was sighted that confirmed that individual needs, ethnic, cultural, spiritual values and beliefs were being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family/whānau interviewed reported they had neither witnessed or experienced any discrimination, coercion, harassment, sexual, financial, or other exploitation. Residents felt safe and reported positively on all aspects of interactions with staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, diabetes nurse specialist, wound care specialist, and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Posters in the staffroom advertised external study days for wound management. The facility is also linked into 'healthLearn', an online education base. All RNs are signed up to complete a professional development and recognition programme.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family/whānau members interviewed stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Staff understood the principles of open disclosure and had attended a training session on 16 October 2017 related to this. Open disclosure is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was not required.</p>
<p>Standard 1.2.1: Governance</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>objectives and the associated operational plans. A sample of monthly reports to the owners showed adequate information to monitor performance is reported including occupancy, financial performance, emerging risks and issues and human resources requirements.</p> <p>The service is managed by a GM who holds relevant qualifications and has been in the role for less than a year. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The GM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through conferences and sector meetings. The organisations philosophy reflects a person/family centred approach.</p> <p>The service holds contracts with district health board (DHB) for respite, hospital (medical and geriatric services) rest home, dementia services and palliative care. Twenty-six residents were receiving hospital level care, nineteen rest home level care and eighteen dementia care at the time of audit. There were no residents under the other contracts at the time of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>When the GM is absent, the clinical manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a registered nurse (RN) who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and adverse events. However, not all data is analysed and evaluated to identify trends.</p> <p>Meeting minutes reviewed confirmed regular review of quality indicators and that related information is reported and discussed at the quality improvement team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and attendance at meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed a lack of outings in the van. The service has engaged a volunteer driver to increase van rides. Resident meeting minutes confirmed they are now satisfied with the number of van outings.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements,</p>

		<p>including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The general manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and discussed at the quality improvement and staff meetings, but not analysed (refer criterion 1.2.3.6).</p> <p>The manager described essential notification reporting requirements, including for pressure injuries. She advised there have been notifications of significant events made to the Ministry of Health regarding an outbreak, security breach, power and call bell outage since the previous audit. All events have been managed and resolved or closed out.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and then annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. An external assessor provides regular assessments for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Observations and review of four weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the 15 residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Residents' files are held in the nurses' station of each wing which was locked when staff were not present.</p> <p>Archived records are held securely on site and are readily retrievable if required.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission. An information booklet detailing services offered, sample menus, activities and introduction of staff members is provided along with information about what the admission process involves. A tour of the facility provides opportunity to view vacant rooms, meet staff and ensure needs would be met, in one of the three areas of care provided, hospital, rest home and dementia care. On acceptance of a placement the organisation seeks updated information from the NASC and/or GP for residents accessing respite care.</p> <p>Specialist referral to the dementia service is confirmed, including the consent of Enduring Power of Attorney (EPOA) for admission.</p> <p>Family/whānau members and residents interviewed stated they were satisfied with the admission</p>

		<p>process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail and assessments. Signed admission agreements are kept in the manager's office in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHBs 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. If transferring to another facility a verbal handover is given.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day 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 administer medicines are competent to perform the function they manage. A competency register and specimen signatures were sighted.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p>

		<p>There is an implemented process for comprehensive analysis of any medication errors, and this was recently utilised for three medication errors that has since been reviewed and closed out. The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. Medication errors made since last audit have been handled appropriately. Errors are equally divided between pharmacy and administration.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a team of three cooks and three kitchen hands. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. The menu is in line with recognised nutritional guidelines for older people.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Food Check South. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's needs, is available.</p> <p>A mealtime observed was noted to be quiet and unrushed. Sufficient room was available for residents to move freely between tables.</p> <p>Evidence of resident satisfaction with meals was verified by residents and family interviews as well as satisfaction surveys.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family/whānau. The facility manager gave an example of how a resident was declined due to specific needs which could not be safely met on the night shift.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as, a pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify needs for initial care. The interRAI assessments are then completed within 21 days and incorporated into the long-term care plan. The sample of care plans reviewed had an integrated range of resident-related information. All residents had a current interRAI assessment completed by one of four trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Behaviour management plans with potential triggers are in place for residents in the dementia service.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff through hand over and progress notes and short-term care plans as required. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of</p>	FA	<p>The activities programme is provided by three activities staff. The staff member interviewed commences her diversional therapy training next week.</p> <p>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</p>

<p>the service.</p>		<p>are evaluated three monthly and as part of the formal six-monthly care plan review. Tick charts were sighted showing residents participation.</p> <p>Residents interviewed were happy with the range and variety of activities. Activities advertised on monthly calendar included newspaper reading, singing groups, van outings, games and pampering sessions. Several lounges around the facility had jigsaw puzzles set out and different residents throughout the day added to it.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are combined between the wings for some activities and others are for individual wings. One to one sessions are held for those less able to participate in groups. Activities are offered at times when residents are most physically active and/or restless. This included activities provided in the evening, such as doll therapy, 'fiddle' boxes and music.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the intervention of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for skin infections and wounds. Unresolved problems are added to long term care plans. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Residents keep their own GPs if they are in the local area and are able to be contacted in an emergency. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files to wound specialist care. The resident and the family/whānau are kept informed of the referral process, as verified by interviews with family/whānau. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous</p>

<p>Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored. Staff interviewed knew what to do should any chemical spill/event occurred.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 13 December 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The environment in the dementia service allows for purposeful walking both inside and to safe outside areas. Residents were observed accessing the external areas from one of several doors that open to the secure outside space.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a mixture of communal areas and full ensembles. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with</p>

<p>Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Several smaller communal spaces were observed being used on the days of audit. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry by designated staff. Laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the external contractor for chemicals, and the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 25 August 2016. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 20 April 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the full number of residents. Water storage tanks are located around the complex, and there is a generator</p>

		<p>available for the site. Emergency lighting is regularly tested. Oxygen cylinders are not securely stored, or their content status checked.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Many have doors that open onto outside patio area. Heating is provided by panel heaters in residents' rooms and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. Audit records confirmed this.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to quality meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for six months. She has attended relevant study days as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p>

organisation.		The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. During a recent outbreak, measures were in place that enabled it to be contained to one wing.
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 prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and 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 verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing and advice about remaining in their room if they are unwell.
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 long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal tract and the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover and documented in progress notes to ensure early intervention occurs.  Monthly surveillance data is collated, graphs formulated and discussed but there is no formal documentation of analysis, identification of trends, possible causative factors and required actions. (see corrective action Standard 1.2.4).  A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been

		incorporated into practice, with additional staff education implemented.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, seven residents were using restraints and six residents were using enablers, which were the least restrictive and used voluntarily at their request. All restraints were bedrails and raised for safety overnight. A similar process is followed for the use of enablers as is used for restraints. All restraints and enablers were in use in the hospital area of the facility.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. For example, a resident previously using a chair restraint has had this removed, with additional strategies put in place to ensure the resident remains safe.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	FA	<p>The restraint approval group, made up of the clinical care manager, registered nurse and the general practitioner, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/EPOA. The restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were</p>

		sighted in the records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds. A low bed was purchased on the day of audit for trial with one resident.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality and staff meetings. Minutes of meeting reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with staff confirmed that the use of</p>

		restraint has been reduced by two over the past year.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Quality data is collected for all adverse events, falls and infections, documented and discussed at the quality improvement team meeting and staff meetings. However, there is no documented analysis of the data.</p> <p>Quality meeting minutes suggest that each event is discussed by person, for example – three falls in the past month – however, there is no evidence of an analysis occurring to identify any trends or interventions to minimise the risks. An example is the addition of sensor mats for a resident who is a falls risk to alert staff, and while this is added to the resident's notes and care plan it is not included in the quality improvement data, including the effectiveness of the implementation.</p>	Quality improvement data is not routinely analysed and evaluated to identify trends that will lead to improvements.	<p>All quality data is analysed and evaluated to identify trends that lead to improvements of the service.</p> <p>180 days</p>

<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA Low</p>	<p>The facility has residents who require oxygen either routinely or in an urgent situation. However, those sighted in storage were not secured and it was unclear on one cylinder of the oxygen content status.</p>	<p>Three oxygen cylinders and two cylinders in the empty cylinder space were not secured. It was unclear on one cylinder of the content status (full or empty) and there was no evidence of a documented routine check of the status of the oxygen cylinders.</p>	<p>Oxygen cylinders are secured when in storage and there is a clear process for identifying the status of the content of the cylinders.</p> <p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.