

Radius Residential Care Limited - Radius Heatherlea Care Centre

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Radius Heatherlea Care Centre

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

Dates of audit: Start date: 24 April 2018 End date: 24 April 2018

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: 49

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

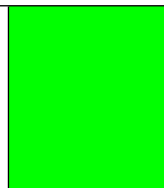
Heatherlea Care Centre is owned and operated by Radius Residential Care Limited and is certified to provide rest home, hospital (medical and geriatric) and dementia level care for up to 55 residents. On the day of the audit there were 49 residents. The facility manager and clinical nurse manager are appropriately qualified and experienced. Interviews with residents and family member confirmed overall satisfaction with the care and service provided.

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

Five of the five previous audit findings have been addressed around providing the appropriate staff training, registered nurse 24-hour cover, suitable equipment, the employment of appropriate staff to provide hospital level care, and the timeliness of general practitioner (GP) assessments on admission.

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.

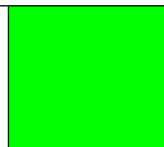


Standards applicable to this service fully attained.

Discussions with families identified that they are fully informed of changes in health status. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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.



Standards applicable to this service fully attained.

The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Resident meetings are held two monthly and residents/families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. An orientation programme is in place for new staff. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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.

The registered nurses are responsible for each stage of service provision. Initial assessments, care plans and evaluations are completed by registered nurses within the required timeframes. Care plans and work logs (developed on the electronic resident system) are written in a way that enables all staff to clearly follow their instructions. The general practitioner reviews residents at least three monthly. There is allied health professional involvement in the care of the residents. The activity programme is varied and interesting and includes outings, entertainment and links with the community. Each resident has an individual leisure care plan. The rest home and hospital have an integrated programme. The activities in the dementia unit are flexible and meaningful. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are prescribed and administered in line with appropriate guidelines and regulations. Meals and baking are prepared and cooked on-site. The menu is varied and appropriate, and has been reviewed by a dietitian. Individual and special dietary needs are catered for. Alternative options are provided. There are nutritious snacks available 24 hours.

Safe and appropriate environment

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

Standards applicable to this service fully attained.

The building has a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were no residents with restraints and one resident using an enabler.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Standardised definitions are used for the identification and classification of infection events. The infection control coordinator (clinical nurse manager) is responsible for the collation, analysis and trending of data. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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>A complaints policy and procedure is in place. The complaints procedure is provided to residents and their family within the information pack at entry. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaint forms. Complaint forms are available at reception. Three complaints were made in 2017 and two received in 2018 year-to-date. A review of the complaints register evidences that the appropriate actions have been taken and the complainant received documented outcome of the complaint. One of the complaints received in 2018 was made through the Health & Disability Commissioner (HDC), which has been investigated. Heatherlea Care Centre are awaiting a response from HDC to a follow-up letter in April 2018.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Four residents (one rest home and three hospital) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. Twelve incident reports reviewed evidenced recording of family notification. Five relatives (four rest home and one hospital) interviewed, confirmed they are notified of any changes in their family member's health status. Two monthly resident meetings provide a forum for residents to discuss issues or concerns. Families are encouraged to visit. An introduction to the dementia care unit booklet provides information for family, friends and visitors to the facility. The facility has an interpreter policy to guide staff in accessing interpreter services.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Heatherlea Care Centre is part of the Radius Residential Care group. The service provides rest home, hospital (medical and geriatric) and dementia level care for up to 55 residents. On the day of the audit, there were 23 rest home residents including one resident on a 'younger persons with disability' (YPD) contract, 10 hospital residents including one resident under medical services contract and 16 of 21 dementia level residents. There are 19 rest home beds that are dual-purpose to provide hospital level care. All other residents were on the aged related residential care (ARRC) contract.</p> <p>The Radius strategic plan describes the vision, values and objectives of Radius aged care facilities. The service organisation philosophy and strategic plan reflect a person/family-centred approach. An annual business plan 2017/2018 for Heatherlea Care Centre describes specific and measurable goals that are reviewed each month. The business plan is updated annually.</p> <p>The facility manager is a business manager who has been in the role for seven years. She is supported by a clinical nurse manager and a regional manager (who was present on the day of the audit). The clinical nurse manager started in the position in January 2018.</p> <p>The facility manager has maintained at least eight hours of professional development activities related to managing an aged care facility.</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>	FA	<p>There is an organisational business plan that includes quality goals and risk management plans for Heatherlea Care Centre. Quality and risk performance is reported across facility meetings and to the regional manager. The facility manager advised that she is responsible for providing oversight of the quality programme. There is a monthly staff meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff. Required actions and resolutions from facility meetings are consistently documented. Resident/family meetings are held every two months. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in February 2018 was at 94%, an increase of 4% from the prior year.</p> <p>The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The clinical managers group, with input from facility staff, reviews the service's policies at national level every two years. Clinical guidelines are in place to assist care staff. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions are evaluated and signed off when</p>

		<p>completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative (HCA) interviewed confirmed their understanding of health and safety processes. She has completed the external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC Workplace Safety Management Practice. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.</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>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Incidents are included in the Radius key performance indicators (KPI). There is a discussion of incidents/accidents at monthly staff and quality/health and safety meetings including actions to minimise recurrence. A review of twelve incident/accident forms from March 2018 identified that forms are fully completed and include follow-up by a RN. Neurological observations are carried out as per protocol for any potential injury to the head. Discussions with the facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications made since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (one clinical nurse manager, one RN, two healthcare assistants (HCA) and one diversional therapist) include a comprehensive recruitment process, which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN staff and other health practitioner practising certificates is maintained. Registered nurses are supported to maintain their professional competency. The orientation programme provides new staff with relevant information for safe work practice and the provision of hospital level care. This previous finding around staff orientation has now been addressed. Staff are required to complete written core competencies during their induction. These competencies are repeated annually.</p> <p>There is an implemented annual education and training plan that exceeds eight hours annually. There is an</p>

requirements of legislation.		attendance register for each training session and a staff member record of training. Specific hospital level care training has been provided to care staff, (ie, diabetes, hoist, wound care, skin integrity, pressure area and medication/pain management training). Registered nursing training and advice (eg, specialist nursing wound care management) is available through the local district health board (DHB). There is a RN on duty at all times 24/7. This previous finding around staff training and RN 24/7 cover has now been addressed. One of five RNs have completed their interRAI training. The clinical nurse manager is also interRAI trained. There are twenty HCAs that work in the dementia unit and seventeen have completed the required dementia standards, one HCA is in process of completing their dementia standards and the two HCAs that have not completed have commenced work in the last 12 months.
<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>A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday and are available on call 24/7. The facility is split into five wings; Fuchsia and Azalea (both on the ground floor), Boronia, Jasmine, and Camellia (all upstairs).</p> <p>In the Fuchsia wing there are 15 of 15 residents in total (11 rest home and four hospital) and in the Azalea wing there are nine of nine residents in total (seven rest home and two hospital); there is one RN on duty on the morning and afternoon shift, and one on the night shift. They are supported by three HCAs (two long shift and one short shift) on the morning shift, three HCAs (two long shift and one short shift) on the afternoon shift and two HCAs on the night shift.</p> <p>In the Boronia wing there are nine of ten residents in total (five rest home and four hospital); there is one HCA on the morning and afternoon shifts and one HCA on the night shift.</p> <p>In the dementia unit, (Jasmine wing) there are eight of nine residents and there are eight of twelve residents in Camellia wing. There are two HCAs on duty in both the morning and afternoon shifts and one on the night shift.</p> <p>Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. The clinical nurse manager and RNs on duty in the rest home/hospital area cover the dementia unit. In the dementia unit staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers. Interviews with three HCAs identified that staffing is adequate to meet the needs of residents and that any replacement staff required due to absenteeism are always replaced.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p>	FA	<p>The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses and senior HCAs administer medications and have completed medication competencies and medication education. Medications are delivered in robotic packs with documented evidence that these have been checked against the medication chart. All medications were stored safely within one main medication room. All</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>medications were within the expiry date. All eye drops in use were dated on opening. There were no self-medicating residents. Ten medication charts (paper-based) were reviewed (four hospital, four rest home and two dementia care) met prescribing requirements. All medication charts identified an allergy status and had photo identification.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food and baking are prepared and cooked on-site by qualified cooks supported by morning and afternoon kitchenhands. A contracted company oversees the food services. There is a four-weekly menu that has been reviewed by a dietitian. The service accommodates special diets such as diabetic desserts and strict vegetarian, and provide alternatives for dislikes. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. The cook is notified of any changes to resident's dietary requirements. The cooks plate the meals, which are delivered to the units in scan boxes.</p> <p>There is special equipment available for residents if required. Serving temperatures are taken and recorded. There are nutritious snacks available 24 hours. The temperatures of refrigerators, freezers and chiller are monitored and recorded daily. End-cooked meat temperatures are taken and recorded twice daily. All food is stored appropriately and dated. A cleaning schedule is maintained. The current food control plan was verified November 2017 and valid for one year. Residents and the family members interviewed commented positively about the quality and variety of food served.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses and HCAs follow the detailed and regularly updated care plans and report progress against the care requirements each shift. If a resident's health status changes the RN initiates a GP or nurse specialist review. Relatives interviewed state they are contacted for any changes in the resident's health. Staff have access to sufficient medical supplies including dressings. Wound assessment and care plans, wound review plans and evaluation notes were in place for six residents with wounds.</p> <p>Three hospital residents with pressure injuries (resident with three healing stage pressure injuries, one resident with two healing unstageable pressure injuries and one resident with four stage one pressure injuries). The clinical nurse manager has access to specialist nursing wound care management advice through the DHB. Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Electronic monitoring forms are completed and reviewed for example turning charts, food and fluid charts, blood pressure, weight charts, behaviour charts, blood sugar levels and neurological observations, however a shortfall was identified around weight loss and behaviours.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A registered diversional therapist (DT) has been in the role for four years and is employed 9.00 am to 4.30 pm Monday to Friday. The DT is supported by an activities coordinator 10.00 am to 5.00 pm Monday to Friday. The DT is based in the rest home/hospital and oversees the activity programme for the dementia care unit. The activity coordinator rotates through the areas with a set 3.00 pm to 5.00pm programme implemented in the dementia care unit daily. There are adequate resources for healthcare assistants to incorporate activities for residents into their duty. The rest home and hospital programme are integrated and includes music, board games, newspaper reading, baking, arts, walks, hand massage, poetry, reminiscing and happy hours. One-on-one time is spent with residents who choose not to or are unable to participate in group activities.</p> <p>Community visitors include entertainers and guest speakers. Residents from the dementia unit attend group activities in the rest home/hospital as appropriate and under supervision. The activity programme for dementia care residents is flexible and focused on meaningful activities, small group activities, one-on-one time and reminiscing. There are outings and drives into the community for all residents (as appropriate). All resident files reviewed on the electronic system have an individual life history and leisure care plan that is evaluated at least six monthly. Residents and families interviewed commented positively on the activity programme. Residents have the opportunity to feedback on the activity programme through the two monthly resident meetings, which is also open to families to attend.</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>All initial interim care plans are evaluated by the RNs within three weeks of admission. Electronic evaluations (multidisciplinary – MDT case conference) are completed at least six monthly. In the electronic files reviewed the long-term care plan was evaluated at least six monthly for two rest home residents and one dementia care resident who had been at the service six months. Two hospital residents had not been at the service long enough for a six-monthly evaluation. There is at least a three-monthly review by the GP. Written evaluations identify if the resident/relative goals are met or unmet. Short-term care plans sighted on e-case have been evaluated and resolved or added to the applicable long-term care plan if the problem is ongoing.</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</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 1 September 2018. There is a reactive and planned maintenance programme that includes testing and tagging of electrical equipment, calibration of medical equipment and hot water temperatures. Essential contractors are available 24 hours. The facility has wide corridors and rails for residents to mobilise safely, using mobility aids. The external areas and courtyards provide seating and shade. Residents have access to safely designed external areas. The dementia unit has a spacious outdoor courtyard with a safe walking pathway. Seating and shade is provided. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. The service has purchased hospital level of care equipment including hoists (standing and lifting). The previous finding around the provision of hospital level of care equipment has been addressed.</p>

their purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme. Infections are collated monthly, including urinary tract, upper respiratory and skin infections. The data is analysed for trends and corrective actions put in place where required. The service submits data monthly to Radius head office where benchmarking is completed. Infection control data is reported monthly to the quality meetings and combined infection control/health and safety meetings. There have been no outbreaks.</p>
<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 include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were no residents with restraints and one resident using an enabler (bed loop). Staff training has been provided around restraint minimisation in April 2017. The resident's file using an enabler showed that enabler use is voluntary and included appropriate assessment, consent and monitoring. The clinical nurse manager is the restraint coordinator.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.