# Oceania Care Company Limited - Heretaunga Home & Village

## Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Heretaunga

**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 October 2018 End date: 25 October 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:** 44

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Heretaunga Rest Home and Village provides rest home, hospital and dementia level care for up to 58 residents. There were 44 residents residing at the facility on audit days.

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

The residents and family members interviewed spoke positively about the care provided.

There were two areas identified as requiring improvement relating to adverse events and care plan interventions.

## 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. |

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process, and the Nationwide Health and Disability Advocacy Service is accessible to residents, family and staff. Residents and family members confirmed their rights are being met; staff are respectful of their needs and communication is appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent is practised and written consent is obtained when required. Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

There are policies and procedures about the management of complaints that align with Right 10 of Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Complaints are managed according to policy and a complaints register is maintained.

## 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 medium or high risk and/or unattained and of low risk. |

Oceania Healthcare Limited is the governing body and is responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned.

The facility is managed by a business and care manager with aged care management experience. The clinical manager is responsible for the oversight of the clinical services in the facility. There are systems in place for monitoring the services provided, including regular monthly reporting by the business and care manager to the Oceania national support office.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented on accident/incident forms. Facility meetings are held and meetings include reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

There are policies and procedures on human resource management and these are implemented. A mandatory education programme is provided for staff.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice.

The privacy of resident information is maintained. The name and designation of staff making entries in clinical files is recorded and legible.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The business and care manager has primary responsibility for managing entry to the service with support from the clinical manager and registered nurses.

Residents receive services from staff who are suitably experienced and qualified. Assessments are completed using interRAI. The initial assessments and initial care plans are conducted within the required timeframes. Long-term care plan evaluations are documented and resident-focused. The residents and family members have an opportunity to contribute to care plans and evaluations of care.

Medication policies reflect legislative requirements and guidelines. Medicines are managed in line with legislation and guidelines. Registered nurses and senior health care assistants are responsible for administration of medicines and complete annual medication education and competencies.

There are two group activities programmes developed, one for hospital and rest home level residents and one for residents with dementia. The activities programmes include meaningful activities that meet the recreational needs and preferences of the residents. Snacks are available 24 hours.

At Heretaunga Home and Village all meals are prepared on-site. Residents’ individual food preferences, dislikes and dietary requirements are catered for.

## 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 underwent external recladding and refurbishments in 2017. The bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids, and to allow for care to be provided. Lounges, dining areas, and sitting alcoves are available for residents and their visitors. The external areas have been upgraded and new gardens planted. There is a safe internal and external environment in the dementia unit. A current building warrant of fitness was displayed.

There is a preventative and reactive maintenance programme in place. Staff interviews confirmed awareness of the processes for reactive maintenance requests to ensure timely repairs are conducted. Visual observation evidenced equipment is maintained to an adequate standard, and testing and tagging of equipment and calibration of biomedical equipment is current.

A call bell system is available to enable residents to access help when needed. Security systems are in place with regular fire drills completed.

Protective equipment and clothing are provided and used by staff. Chemicals are safely stored. Cleaning of the facility is conducted by household staff and monitored. The laundry service is contracted out.

## 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. |

Policies and procedures comply with the standard for restraint minimisation and safe practice. The restraint minimisation programme defines the use of restraints and enablers. Restraint minimisation is overseen by the clinical manager. The service has a current, up-to-date restraint register. There was one resident using restraint and there were no enablers in use on audit days.

## Infection prevention and control

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

The infection control programme, content and detail are appropriate for the size, complexity and degree of risk associated with the service. The service provides an environment which minimises the risk of infections to residents, staff and visitors.

Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. Staff demonstrated adherence to accepted good practice principles around infection control.

Specialist infection prevention and control advice can be accessed from the district health board; microbiologist, general practitioners and infection control specialists if needed.

The clinical manager is the infection control nurse. Aged residential care specific infection surveillance is undertaken, analysed, trended and results are reported to management and staff.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 48 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 0 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Policies, procedures and processes are in place to meet the obligations in relation to the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code. Staff were respectful of residents’ rights as observed in their communications with residents and family members; encouragement of residents’ independence; and maintenance of residents’ dignity and privacy. Training on the Code is included in the staff orientation process and part of the annual mandatory training and education days for all staff. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The informed consent policy guides staff in relation to informed consent and staff interviewed understood the principles and practice of informed consent.  The residents’ files evidenced documented consents using the organisation’s consent form that includes consent for photographs, outings, and collection and sharing of health information.  There was evidence of advance directives signed by the residents. Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with their relative and consulted when treatment changes were being considered.  Enduring power of attorney documentation is included in clinical records of residents’ with dementia, with evidence of supporting legal documents.  Staff were observed gaining verbal consent for day to day care. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. Staff demonstrated understanding of the advocacy service, with contact details for the service readily available at the facility.  Residents are provided with information on the advocacy service as part of the admission process. Residents and family members confirmed their awareness of the service and how to access this. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to maintain their community interests and networks, and to visit with their families. The activities programme includes regular outings in the facility’s mobility van and participation in community events. Community groups and entertainers also visit the facility.  The service welcomes visitors and has unrestricted visiting hours. Family members advised they feel welcome when they visit. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Policies and procedures relating to complaints management are compliant with Right 10 of the Code. Systems are in place that ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. The complaints forms are displayed and accessible within the facility. Staff interviews confirmed their awareness of the complaints processes. Residents and families demonstrated an understanding and awareness of these processes.  The BCM is responsible for complaints management. There are no complaints with other external agencies, as confirmed at BCM interview.  The review of all 2018 complaints evidenced the required processes relating to Right 10 of the Code were consistently followed. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | New residents and their family are given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service on admission to the facility. Posters on the Code and advocacy brochures are displayed throughout the facility.  Residents and family members interviewed were familiar with the Code and the advocacy service. Residents and family stated they would feel comfortable raising issues with staff and management. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff communicated their knowledge about the need to maintain residents’ privacy and were observed doing so throughout the audit.  Residents are encouraged to maintain their independence by participating in community activities and outings, as confirmed at resident and family interviews. Residents’ care plans include documentation relating to residents’ abilities and strategies to maximise independence. Residents’ records sampled confirmed that residents’ individual cultural, religious, social needs, values, and beliefs were identified, documented, and incorporated into their care plan.  The policy on abuse and neglect was understood by staff interviewed, including what to do should there be any signs. Education on abuse and neglect is part of the staff orientation programme and the mandatory staff study days.  The residents and their families confirmed they receive services in a manner that has regard for their dignity, privacy, spirituality, and choices. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has a Māori health plan that guides staff in meeting the needs of the residents who identify as Māori. Māori health, cultural safety and values are part of staff orientation and the in-service education programme. Any additional cultural support, if required, would be accessed locally, as confirmed at business and care manager (BCM) interview. At the time of the audit there were no residents who identified as Māori.  Family can visit their family members at the facility and are part of the care planning and evaluation care process. Interviews with family confirmed they were informed of their family member’s changes in condition when this occurred, are invited to residents’ meetings, receive newsletters, and are involved in multidisciplinary reviews. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The individual preferences, values and beliefs of residents were documented in the care plans reviewed. Residents and family members stated they had been consulted about residents’ individual ethnic, cultural, spiritual values, and beliefs, and confirmed that these were respected. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members stated that residents were free from any type of discrimination or exploitation.  Staff are guided by policies and procedures and communicated understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. Staff orientation includes information related to all forms of discrimination and exploitation, professional boundaries and expected behaviours. The annual mandatory staff education includes topics such as: professional boundaries; code of conduct and abuse and neglect. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The Oceania Healthcare Limited (Oceania) support office review policies to encourage good practice.  The service encourages and promotes good practice through evidence-based policies and procedures, input from external specialist services and allied health professionals, for example: physiotherapists and wound care specialists. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | A review of accident/incident forms showed timely communication with residents and or family members. Communication with family members is also recorded on the communication forms located in the residents’ clinical files. The residents and family members stated they were kept informed about any changes to their own or their relative’s status and were advised about incidents/accidents and the outcomes of medical reviews. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  The admission agreement is provided for all new residents and their families and includes all relevant information required under the aged related residential care (ARRC) contract. The admission agreements are signed by the resident or family and Oceania representative in timely manner. The family members of residents with dementia receive additional information such as written documentation on the dementia unit practices.  Residents and family members are informed of residents’ meetings and the meeting minutes reviewed evidenced relevant information is shared. The interviews with families confirmed they are informed of the facility’s events through the facility newsletter and invitations to participate in meetings and education sessions. There was evidence of a family meeting arranged for family members of new residents with dementia to provide support and connect families together. Interviews with family members confirmed this meeting provided support for them. There was evidence of invitations to family to attend in-service education sessions on understanding challenging behaviours and enduring power of attorney (EPOA) responsibilities, which were provided by an external specialist at the facility.  Interpreter services can be accessed via the district health board (DHB). The BCM stated there were no residents requiring interpreter services at the time of audit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Heretaunga Rest Home and Village is part of the Oceania Healthcare Limited (Oceania). The Oceania executive management team provide support to the facility with the regional clinical and quality manager providing support during the on-site audit. The BCM provides the executive management team with monthly management reports against identified indicators. The Heretaunga operational and business brief is documented and was sighted.  There is a clear mission of the organisation with values and goals and these are communicated to residents, staff and family through posters at the entrance to the facility. The BCM is responsible for the overall management of the service and has been in this role for approximately two years. They are currently also managing an Oceania facility in the South Island while the support office staff appoint a new manager for that facility. The BCM has experience in management. The BCM is supported by a clinical manager (CM) who is responsible for the oversight of clinical services. The CM is a registered nurse (RN) and has been in this position for approximately six years.  The facility can provide care for up to 58 residents, with 44 beds occupied at the audit. This included 20 residents requiring rest home level care, 6 residents requiring hospital level care and 18 residents in the dementia unit.  One resident at rest home level care and one resident with dementia were under the hospital respite Accident Compensation Corporation (ACC) contract following surgical interventions at the DHB.  The facility includes hospital and rest home level services under occupational rights agreements (ORA). The services for residents with ORA are the same as services for rest home and hospital services for residents under the ARRC contract and other contracts at the facility. There were seven rest home residents and one hospital resident residing in the apartments and studio care suites with ORAs. The review of the Heretaunga site plan, visual observation, documentation review and interviews with staff and residents evidenced the hospital and the rest home residents under the ORA contracts have access to appropriate care. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the BCM, the CM is delegated to perform this role, with support from the regional operations manager and the regional clinical and quality manager. For extended leave of the BCM or the CM, Oceania’s support office staff would assign the responsibility of these positions, as confirmed at BCM and regional clinical quality manager’s interviews. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The Oceania quality and risk management framework is documented and implemented at the facility. Service delivery is monitored through quality activities, including but not limited to: complaints; review of incidents and accidents; key performance indicators; and implementation of an internal audit programme. The review of the quality and risk management data evidenced the data is collected, collated and trends are identified. Where deficiencies are identified, corrective action plans are documented and implemented. Resident and family satisfaction surveys are completed six monthly. Review of two satisfaction surveys conducted in 2018 recorded overall satisfaction with services provided. The facility is part of the Oceania benchmarking programme and the benchmarking data is shared with relevant management and staff. Facility meetings are conducted and minutes evidenced communication with staff around aspects of quality improvement and risk management. Staff report that they are kept informed of quality improvements.  The service implements organisational policies and procedures to support service delivery, including policies on interRAI. All policies are subject to reviews as required with all policies current. Support office reviews policies with input from relevant staff and management. Policies are linked to the Health and Disability Sector Standards current and applicable legislation and evidenced-based best practice guidelines. Policies are readily available to staff. New and revised policies are presented to staff to read and staff sign to evidence that they have read and understood the policy. The staff confirmed that they are provided with new and revised policies and the opportunity to read and understand the policy.  The organisation has a risk management programme in place that records management of risks in clinical, environment, human resources and other areas specific to the facility. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed, and risks are minimised or isolated. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate | Policy and procedures reference essential notification reporting; for example, health and safety, human resources, and infection control. The BCM is aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks; and changes in clinical managers. There had been no events requiring essential notifications to external agencies.  Staff interviews evidenced staff understanding of the adverse event reporting process and the importance of recording near misses. Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond to the event. Accident/incident forms are reviewed by management and signed off when completed. The RNs undertake assessments of residents following an accident, however, neurological observations are not always completed following unwitnessed falls. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Written policies and procedures in relation to human resource management are available. Current copies of annual practising certificates were reviewed for staff and contractors that require them to practice. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities, and authority. These were reviewed on staff files along with employment agreements, reference checks, and police vetting.  Interviews with health care assistants (HCA) confirmed new HCAs are paired with a senior HCA for shifts or until they demonstrate competency on a number of tasks including personal cares for residents. Health care assistant interviews confirmed their roles in supporting and buddying new staff. Completed orientations were sighted in staff files reviewed.  Competency assessment questionnaires for relevant competencies required for specific positions, such as: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; restraint; nebuliser; blood sugar and insulin; and assisting residents to shower were sighted in staff education files reviewed.  There are four RNs, including the CM, that were interRAI competent.  The organisation has a mandatory education and training programmes with annual training days provided for clinical and non-clinical staff. The clinical staff in the dementia unit have the relevant education relating to dementia care. The residents who are receiving rest home care and hospital level care in ORA units have their needs met within the environment in which they live and are supported by appropriate staff to meet their needs. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staffing levels meet contractual requirements. The BCM and the CM are available during weekdays and on call after hours and weekends. Adequate on-site RN cover is provided 24 hours a day, 7 days a week. Registered nurses are supported by sufficient numbers of HCAs.  There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Rosters sighted reflected that staffing levels meet resident acuity and bed occupancy.  Residents and families reported staff provide them with adequate care. Care staff reported there are adequate staff available and that they can get through their work.  The residents who are receiving rest home care and hospital level care in ORA units have their needs met within the environment in which they live with 24-hour care and sufficient staffing and availability of RNs to meet their needs in accordance with the aged related residential care agreement. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of residents’ records. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.  Residents’ files are maintained securely. Electronic data is password protected and can only be accessed by designated staff. Archived material is also kept securely and is easily retrievable.  All components of the residents’ records reviewed include the resident’s unique identifier. The clinical records reviewed are integrated, including information such as medical notes, assessment information, and reports from other health professionals. Entries are legible, dated and signed by the HCA, RN or other health professional, and include their designation. Resident progress notes are completed every shift, detailing resident response to service provision. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Needs Assessment and Service Coordination (NASC) assessments are completed for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the resident’s level of care requirements. There is a comprehensive information pack provided to all residents and their families prior to admission. Review of residents’ files confirmed entry to service processes, ensuring compliance with entry criteria. Interviews with residents and family and review of records confirmed the admission process was completed by staff in a timely manner. Residents and family members interviewed stated they had received the information pack and had received enough information prior to and on entry to the service. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a policy that describes guidelines for discharge, transfer documentation and follow-up. A record is kept and a copy is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Interviews with staff and review of documentation confirms there is open disclosure between the service and family/whānau, including adverse event reporting. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Medication management policies and procedures provide guidelines to ensure safe medication management practices Medicines are provided by the pharmacy in a pre-packed delivery system. Medicines are stored in locked medicine trolleys which are stored in the medication room. Medicines requiring refrigeration are stored separately in the medicine fridge. Drugs are stored securely with processes meeting medication legislation requirements. Weekly checks and six-monthly stocktakes are conducted and confirmed that stock levels were correct.  The facility uses an electronic system for medicines administration. Medication records are reviewed at three monthly intervals or when the health needs of the resident require review of their medicines. Medication records reviewed included the date, medicine name, dose and time of administration and maximum dosages as required. All medication records have current photo identification and known allergies identified.  Registered nurses and senior HCAs responsible for medicines management complete annual competency testing and education. Safe medicine management practice was observed during the lunch time medication rounds. Processes are in place to enable residents to self-administer medications. There were no residents self-administering medicines. There were no standing orders at time of audit. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Heretaunga has a large commercial kitchen. The service employs a chef who is responsible for the management of the kitchen, including ordering of food, equipment and resources. The chef is supported by two cooks and two kitchen assistants. All kitchen staff have current food safety training.  There is a current, verified food control plan in place. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines, as verified during the on-site audit. Food is plated and served in the main dining room adjacent to the kitchen. This large dining room is open and spacious with a separate seating area for dementia residents. Food is served via bain maries in the care suite area. The kitchen provides a tray service for residents to dine in their rooms if required.  Food, fluid and nutritional needs of residents are in line with recognised nutritional guidelines. There are four-weekly seasonal menus reviewed annually by a dietitian at organisational level. A nutritional profile is completed for each resident by an RN when the resident is admitted to the service. A copy is provided to the kitchen. Food preferences and cultural considerations are noted. Special diets are considered and catered for. There is specialised crockery such as lip plates, mugs and utensils to promote resident independence with meals. Snacks are available 24 hours a day.  Residents and families interviewed reported they are satisfied with the food service. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service has a process in place where access is declined, should this occur. When residents are declined access to the service, residents and their family, the referring agency and the GP are informed of the decline to entry. The residents would be declined entry if not within the scope of the service or if a bed was not available. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Residents are admitted with a care needs level assessment completed by the NASC team prior to admission. Assessments are recorded, reflecting data from a range of sources, including but not limited to: the resident; family; GP and specialists. InterRAI assessments are completed within the required timeframes and available to staff. InterRAI assessments were sighted in all resident files reviewed during the on-site audit.  The interRAI assessment identifies areas where there are increased health needs for the residents and forms the basis of care planning. The RNs interviewed provided evidence of an understanding of the interRAI assessment process and how it is used to accurately identify the health risks, needs and goals of residents. Interviews with staff and review of documentation confirmed continuity of service delivery. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The RNs are responsible for care planning. The long-term care plans provide individual health goals which are based on the residents’ needs as identified through the interRAI assessment process. Short-term care plans are not always developed for the management of acute problems (refer to 1.3.6.1). Residents’ records are integrated and continuity of care is evident. In interviews, residents and family members reported residents’ individual needs are met and they were actively involved in planning of care. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | In files sampled wound care plans, nutrition management, skin integrity management, medical specific plans, pain management and falls prevention plans were evident. Observation charts, weight and neurological observations are recorded (refer to 1.2.4.3). Assessments, monitoring and evaluation around pain were completed and documented. The use of short-term care plans was not always evident. Care planning does not always include specific interventions for both long-term and the short-term problems as per assessed needs.  Discussions with residents, family and staff confirmed care provided is consistent with the needs of the residents. The RNs and HCAs follow the care plan and report progress against the care plan on each shift at handover. Nursing progress notes record changes. Family communication is recorded in the residents’ files.  If external nursing or allied health advice is required, the RNs will initiate a referral (e.g. to the wound care nurse specialist, physiotherapist or podiatrist). Specialist recommendations are followed up. If external medical advice is required, this is be actioned by the GP. Interview with the GP confirmed they provide 24-hour, 7 day a week support. Medical records document reviews at least monthly or more frequently if needed. The GP spoke positively about the service and described effective communication processes. Residents can choose to retain their own GP.  There were sufficient supplies of products and equipment seen to be available that complied with best practice guidelines and met the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The facility provides an activities programme which aims to address the residents’ needs, age and cultural preferences. There are two separate programmes, one for rest home and hospital and one for residents with dementia delivered Monday to Friday. Activities are available for the residents over the weekend supported by the HCAs. Interviews with the BCM and CM confirmed the facility has a plan in place to provide activities for residents with dementia in the early evenings across seven days per week.  Resident files reviewed during the audit process provided evidence of residents having been assessed by the activities coordinator in consultation with the RN. Each resident’s activities assessment includes previous interests and abilities as well as current interests and abilities. There is a 24-hour behavioural activity plan completed for residents with dementia.  The activities programme was reviewed. Each resident is free to choose whether they wish to participate in the group activities programme. Residents can attend any activities on offer. The activities coordinator plans monthly programmes which are then made available to all residents and their families. The monthly programme is overseen and signed off by a diversional therapist. Attendance records are maintained. Each resident has their activities plan reviewed at six-monthly intervals in line with interRAI timeframes.  Residents are encouraged to maintain links with the community through outings with family and van outings organised by the activities coordinator. Birthdays and other special days are celebrated. There are special events held including, but not limited to, fine dining evenings, high teas and luncheons where family and friends are invited to participate. Activities were observed during the days of audit. Residents and families interviewed commented positively on both activity programmes. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | There are monthly reviews by the GP or sooner if required. Long-term care plan reviews are completed six monthly or when the resident’s condition changes. There was documented evidence that RN evaluations were current and completed for all care plans sampled. Resident care is evaluated on each shift and reported in the residents’ progress notes. Short-term care plans are signed off once resolved or added to the long-term care plan if the problem is ongoing (refer to 1.3.6.1). Interviews verified residents and family/whānau are included and informed of all changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. If the need for other non-urgent services is indicated or requested, the GP, RN or CM sends a referral to seek specialist service provider assistance from the DHB. Referral forms and documentation are maintained on resident files.  Referrals are followed up on a regular basis by RN, CM or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies and procedures in place for the management of waste and hazardous substances. There has been a change in the supplier of chemicals and the new supplier has conducted staff training and education in the use of the new system. This education and training was verified in staff records reviewed and interviews with staff and management. The safety data sheets for the use of new chemicals are available and accessible to staff.  Protective clothing and equipment appropriate to the risks associated with waste or hazardous substances being handled is provided and used by staff. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The whole building underwent external recladding and refurbishments in 2017. All residents’ rooms have new carpet, double glazed windows, new joinery and new curtains installed. A current building warrant of fitness was displayed.  There is a preventative and reactive maintenance programme in place. Staff are aware of the processes for maintenance requests to ensure timely repairs are conducted, as confirmed at staff and maintenance interviews.  Visual observation, documentation and staff interviews confirmed the facility and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of biomedical equipment is current.  Hot water temperatures are monitored monthly. When there have been hot water temperatures above the recommended safe temperature, action is taken and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.  The external areas were upgraded and new gardens planted as part of the 2017 refurbishment project. The maintenance of the gardens is contracted out. The dementia unit has external areas and garden that are safe for residents and families to enjoy.  Staff interviews confirmed they have appropriate equipment to meet residents’ needs. Residents stated in interviews they can move freely around the facility and that the accommodation meets their needs. The facility has a van that is used for residents’ outings and this has a current registration. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Bedrooms throughout the facility have a toilet and hand basin or full ensuites. There is one double room that is used for one resident only. The 20 care suites, which include studios and one bedroom apartments, all have full ensuites.  There are adequate number of communal toilets and bathrooms of an appropriate design for residents. Separate toilets are available for staff and visitors. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Communal toilets and showers have a system that indicates if it they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Residents are encouraged to make their room their own, with bedrooms and care suites personalised to varying degrees. The bedrooms are large enough to allow staff and equipment to move around safely and provide personal space for residents. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are separate lounges and dining areas for the rest home and hospital residents, residents with dementia and the residents living in care suites. The environment enables residents to independently access the lounges, dining areas and sitting areas/alcoves within the facility. For residents unable to access these areas independently, staff assist them with access. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not wish to participate in them. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry policies and procedures are in place. Linen and residents’ personal clothes are washed off site at another Oceania facility. There is a separate dirty and clean room available for the laundry service. The staff described the management of laundry at the facility including the transportation, sorting, storage, and the return of clean laundry to the residents.  The cleaner described the cleaning processes and the use of chemicals for cleaning purposes. There are safe and secure storage areas for cleaning equipment and chemicals and staff have access to these areas as required. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility with alcohol gels in various locations.  Residents and family satisfaction surveys evidenced satisfaction with the laundry and cleaning services. The effectiveness of the cleaning and laundry services is audited via the internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems are in place for essential, emergency and security services. The fire evacuation scheme for the facility has been approved by the New Zealand Fire Services. The trial fire evacuations are conducted six monthly. The last fire evacuation education and fire drill was conducted in September 2018. Fire evacuation education and staff attendance at fire evacuation practice training is documented. As a result of a suggestion from residents relating to fire safety, the BCM arranged an in-service fire training for the residents that included: a fire DVD; questions and answers session; evacuation and feedback from residents that participated.  The staff training register evidenced staff who require to have current first aid certificates have completed the training. There is emergency lighting, gas for cooking, emergency water supply, blankets and cell phones available in case of emergency. Emergency equipment accessibility, storage, and stock availability to a level appropriate to the service setting requires review.  The call bell system in place is used by the residents, and/or staff and family to summon assistance if required and is appropriate to the resident groups and settings. Call bells are accessible and available in resident areas. Call bell functions are monitored monthly by the maintenance person. The call bell system will alert the BCM if a call bell is not answered by clinical staff within three minutes of being activated.  Staff interviews confirmed security systems are in place and staff are aware of security processes.  The safety of the rest home and hospital residents residing in ORA units are the same as for the residents under other contracts. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents are provided with adequate natural light and safe ventilation. Residents and families confirmed the facility is maintained at a safe and comfortable temperature.  An area outside the building is available for both residents and staff who smoke. There were no residents who smoked at the facility. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Oceania Healthcare Limited has an established infection control programme. The infection control programme is reviewed annually with the last review in September 2018. The infection control programme, including its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system.  There was a signed infection control nurse job description outlining responsibilities of the position. The CM is the designated infection control nurse with support from the BCM, the regional clinical quality manager, the Oceania infection control committee and infection control team. Infection control meeting minutes are available for staff. Internal audits conducted include hand hygiene and infection control practices.  Visual information is located throughout the facility for visitors, staff and residents’ awareness of infection control procedures to minimise the risk of infection. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control nurse is aware of the need to analyse data and the reasons behind this. The service has access to the infection control nurse specialists and microbiologist at the district health board.  Observations during the on-site audit confirmed implementation of infection prevention and control procedures such as hand washing and the use of anti-bacterial hand gels. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual includes a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, and training and education of staff. The infection control policies link to other documentation and uses references where appropriate. Infection control policies are reviewed as part of the policy review process by Oceania support office. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control education for staff starts at orientation and induction of new staff and ongoing training is provided through the organisation’s annual education and training programme or at an ad-hoc basis when required. The infection control nurse completes training in infection prevention and control through updates at the district health board and e-learning, with the most recent training completed in March 2018. The infection control nurse is responsible for the training of staff in the facility. Resident education occurs as part of the daily care and encouragement of residents to wash their hands and use hand gels when appropriate. |
| 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 | Definitions of surveillance and types of infections are clearly defined and documented to guide staff. The surveillance is appropriate for the size and complexity of services provided. Infection control alerts were documented on the individual residents’ records reviewed. All staff are required to take responsibility for surveillance activities. Interviews with staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers and progress notes. This was evidenced attending handover and review of the residents’ files.  The service submits data monthly to Oceania support office where benchmarking is completed. Infections collated monthly include for example, urinary tract, upper respiratory and skin. This data is analysed for trends and reported to the quality, RN and staff meetings. There have been no infection outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The Oceania restraint minimisation and safe practice handbook and policies comply with this standard and relevant legislation. There is one restraint (bedrails) and no enablers in use at time of audit. The required documentation relating to restraint use was recorded.  Staff and management interviews confirmed the approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The service has policies and procedures in place to guide staff in the management of restraints. Education records sighted evidenced staff received education on restraint minimisation and safe practice. The CM is the restraint coordinator and is responsible for restraint processes at the facility. For the restraint in use at the time of audit, the restraint approval process had been followed and a current consent was in place for the use of restraint. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The resident record reviewed for restraint use included consent and assessment which meet the criteria as outlined in this standard. Culturally safe practice was maintained throughout restraint use, as per care planning. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Interviews with staff and review of the long-term care plan confirmed alternatives to restraint use is considered prior to commencing restraint. The restraint register reviewed was up to date. The register records the residents’ name, the type of restraint being used, when it was initiated and opportunity to record the date of when it is discontinued. Consent for restraint in use at the time of audit was in place and restraint risks recorded. Restraint monitoring is maintained. Staff are aware that advocacy services and support are available, the contact detail is documented, and the services can be accessed when needed. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Interviews with staff confirmed evaluations of any restraint are to be completed at three-monthly intervals. The restraint in use at the time of audit had not been in place for three months and therefore evaluations had not yet been completed. The auditor sighted the evaluation forms intended for use at the time of the three-monthly restraint evaluation.  The restraint coordinator/CM and RNs maintain communication with families regarding restraint use. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint coordinator reports on restraint management at monthly meetings. Interviews confirmed that the restraint approval process forms part of the medical review. The three-monthly restraint review includes effectiveness of the restraint, compliance with policy and procedures, adverse events related to restraint use, and the possibilities of discontinuing restraint.  Consent forms for restraint included timeframes for daily monitoring. Review of restraint consent, at the time of the on-site audit, showed these monitoring times were recorded.  Interviews with staff confirmed that monitoring of restraints is physically taking place according to the frequency as recorded in the consent record. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | There is a policy for staff to follow that details the requirements for observations for residents who have sustained unwitnessed falls.  Review of 12 adverse events relating to unwitnessed falls evidenced all events either did not have neurological observations conducted or when neurological observation was commenced, they were not continued for the required period of observation. The time of neurological observations varied from 1.5 hours to 12 hours. | Neurological observations are not consistently completed as required following unwitnessed falls. | Provide evidence of neurological observations of residents who have sustained unwitnessed falls.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | All resident files reviewed had a long-term care plan in place to guide service delivery. Long-term care plans are developed with the resident, and family/whānau involvement included where appropriate. Progress notes record changes. Not all files sampled had an individualised care plan that covered all areas of identified needs as assessed. For one hospital level resident and two dementia care residents long-term care plans did not document all interventions as assessed. The long-term care plans evidenced not all resident behaviours that challenge were identified. There was no specific reference to triggers or effective distraction/de-escalation techniques. Short-term care plans were completed for wounds and infections. A hospital level resident did not have a short-term care plan for a recent infection. | i) Long-term care plans do not consistently document interventions for current assessed needs.  ii) Short-term care plans are not always used for the management of all short-term/acute problems. | i) Ensure all long-term care plans document interventions for all assessed needs.  ii) Ensure short term care plans are completed for all acute/short term problems.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.