Bupa Care Services NZ Limited - Harbourview Rest Home & Hospital

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 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:	Bupa Care Services NZ Limited
Premises audited:	Harbourview Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 January 2019 End date: 16 January 2019
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	53

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Harbourview is part of the Bupa group. The service is certified to provide rest home and hospital level care for up to 58 residents. On the day of audit there were 53 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, a review of residents' and staff files, observations and interviews with residents, relatives, staff and management. The care home manager has been in the role for 15 months. She is supported by a clinical manager, who has been in the role for a year.

This audit identified the following shortfalls requiring improvement; complaint follow up; implementation of the quality system; training; care plan documentation; implementation of care; evaluation; and call bell audits.

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.		Some standards applicable to this service partially attained and of low risk.

Harbourview endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents.

Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident; promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A process for ongoing education and training for staff is documented and in the process of being implemented. The staffing levels meets contractual requirements. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

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

There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. The medicine charts reviewed met legislative prescribing requirements.

Two part-time activity assistants implement the rest home and hospital activity programme Monday to Friday. The programme includes community visitors, outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for the residents.

All meals and baking are done on-site. Residents' food preferences and dietary requirements are identified at admission and accommodated. The menu is reviewed by the dietitian. Residents commented positively on the meals provided.

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.		Some standards applicable to this service partially attained and of low risk.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current building warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems and training are in place for emergency procedures. There is always a first aider on duty.

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.

Restraint minimisation and safe practice policies and procedures are in place. Enablers are voluntary and the least restrictive option. There were five residents with restraints and four residents who required an enabler during the audit. Appropriate assessments, and evaluations were in place around restraint and enabler use.

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.

Harbourview has an infection control programme that complies with current best practice. The infection control manual outlines a range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. There is a dedicated infection control nurse who has a role description with clearly defined guidelines. The infection control programme is reviewed annually at organisational level.

The infection control programme is designed to link to the quality and risk management system. Infection control education is provided at orientation and incorporated into the annual training programme. Records of all infections are kept and provided to head office for benchmarking.

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	43	0	5	2	0	0
Criteria	0	94	0	5	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.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service. Interviews with eight care staff (four caregivers, three registered nurses and one activity coordinator), reflected their understanding of the key principles of the Code.
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	There are established informed consent policies/procedures and advanced directives. General consents and specific consents where applicable (e.g. indwelling catheter) were obtained on admission and sighted in the eight files reviewed (four rest home and four hospital residents including one younger person and one on respite care) Advance directives if known were on the resident files. Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) were in resident files for residents deemed incompetent to make decisions. An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whanau, are provided with appropriate information to make informed choices

		and informed decisions. Residents interviewed (three rest home and three hospital) and relatives (two of hospital level of care residents) confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. All long-term residents had a signed admission agreement and short-term residents sign a short-stay agreement.
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 advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services (most recent: June 2018).
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 may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held monthly and relative meetings bi-monthly.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint's register. Six complaints received in 2018 were reviewed with evidence of appropriate follow-up actions taken. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the HDC. A complaint made through the local district health board (DHB) in 2018 were investigated and any corrective actions required have been fully signed off. However, it was not possible to evidence that all actions from the action plan were completed. This included: care plan interventions have not been updated to reflect required changes identified through the complaint; call bell audits were not evidenced (link 1.4.7.5); and meeting minutes did not reflect complaints where meetings have been held (link 1.2.3.5). Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, clinical manager and registered nurses (RN) discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Six residents (three rest home level and three hospital level) and two hospital level relatives interviewed report that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.
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	Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There was no evidence of abuse and neglect and staff interviewed could describe a process of reporting should any form of abuse be suspected. Training around abuse and neglect has been provided.
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 is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. At the time of the audit, there was one resident who identified as Māori living at the facility. The service's Kaumatua and four Māori staff attend a Māori Advisory Committee and the service works closely with the local iwi Ngati Toa asking for general advice. Staff receive education on cultural awareness during their induction to the service. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents, although this was not well documented into care plans (link 1.3.5.2).
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 service identifies the residents' personal needs and values from the time of admission. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs (link 1.3.5.2). All care plans reviewed included the resident's social, spiritual, and recreational needs.

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Registered nursing staff are available 7 days a week, 24 hours a day. A general practitioner visits the facility two days a week. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The service receives support from the local district health board (DHB). Physiotherapy services are provided on-site, four hours per week. A podiatrist is on-site every six weeks. The service has links with the local community and encourages residents to remain independent. All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms online. These documents have been developed in line with current accepted best and/or evidence-based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure policy, alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms on Riskman (the electronic data collection software), have a section to indicate if next of kin have been informed (or not) of an accident/incident. Six incident forms were reviewed for November 2018 and all identified that family had been informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health 'Long-term Residential Care in a Rest Home or Hospital – what you need to know' is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they must pay for that are not covered by the agreement.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Harbourview is part of the Bupa group of care homes. The service currently provides care for up to 32 hospital (medical and geriatric) residents and 26 rest home residents. Five beds are dual-purpose. At the time of the audit there were 53 residents (28 hospital residents and 25 rest home residents). There was one hospital level resident on respite and two hospital level residents funded under a younger person disabled contract. All other residents were under the Aged Related Residential Care (ARRC) contract. A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. Harbourview Care Home develops and implement quarterly quality reports on progress toward meeting quality goals, these are forwarded to Bupa continuous service improvements (CSI). The operations manager teleconferences monthly and completes a report to the director of care homes and rehabilitation. There were three 2018 quality goals which also linked to the organisation's quality and health and safety goals. The care home manager has been in the role for 15 months and has previous experience as hospital-based charge nurse in medical services. She is supported by a clinical manager who has been in the role for a year and has previous experience in a hospital-based medical RN role. Staff spoke positively about the support/direction and management of the current management team. The operations manager supports the management team and was present during the audit. The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service.
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	The clinical manager steps in when the care home manager is absent. The operations manager who visits regularly, supports the clinical manager.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and	PA Low	Bupa has a comprehensive quality and risk programme documented for all Bupa services to implement. 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.

maintained quality and risk management system that reflects continuous quality improvement principles.		Policies are regularly reviewed. The service has implemented monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): residents' falls; infection rates; complaints received; restraint use; pressure injuries; wounds; and medication errors. Quality and risk data, including trends in data and benchmarked results are not always documented as discussed in the quality and applicable staff meetings and these meeting have not always been held according to schedule. The Bupa annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are developed when service shortfalls are identified and signed off when completed. Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. There was an annual resident/relative satisfaction survey completed in June 2018 with an 84% overall satisfaction rate. Corrective actions were developed. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes care plan interventions, sensor mats and use of low beds. The service implemented a goal around reducing falls in 2017 and 2018. In 2017, the number of falls had decreased in both the rest home and hospital. The team agreed to implement strategies to decrease falls by 25% in 2018. A falls group was implemented, which includes all clinical disciplines. Strategies have been implemented and progress has been made throughout the year, but the goal not fully met due to a repeat faller in the last quarter.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Policy and procedures are in place that includes definitions and outlines responsibilities including: immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Incident/accident data is linked to the organisation's data collection data base and is used for comparative purposes. A review of six incident/accident forms identifies that forms are fully completed and include follow up by the care manager. Neurological observations were not consistently completed for unwitnessed falls as per policy (link 1.3.6.1). The care home manager and clinical manager are involved in the adverse event process. The care home manager was able to identify situations that would be reported to statutory authorities

		including infectious diseases, pressure injuries, serious accidents and unexpected death. Section 31 reports are completed by head office.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files (one clinical manager, two RNs, three caregivers, one kitchen manager/chef and one activity person) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. Newly employed caregivers complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they will have attained their first national certificates. From this, they are then able to continue with Core Competencies Level 3, unit standards. These align with Bupa policy and procedures. There is an annual education and training schedule, that is yet to be fully implemented. There are seven RNs and six have completed interRAI training. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). There are a number of implemented competencies for registered nurses including: insulin administration; moving & handling; nebuliser; oxygen administration; PEG tube care/feeds; restraint; wound management; syringe driver; and medication competencies.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing levels meets contractual requirements. The care home manager and clinical manager are available during weekdays. The clinical manager is on-call after hours for any organisational concerns and the clinical manager is on-call for any clinical issues. Adequate RN cover is provided 24 hours a day, 7 days a week. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes. The Hospital wing staff for 28 residents includes an RN each shift plus: Caregivers AM: one 7am to 1.30pm; three 7am to 2pm; and two 7am to 3pm. Caregivers PM: one 1pm to 9pm; two 3pm to 10pm; one 5pm to 11pm; and one 3pm to 11pm. The rest home wing, including four rest home residents on a lower floor (25 residents in all) includes:

		Caregivers AM: two 7am to 1pm; and one 7am to 3pm. Caregivers PM: one 3pm to 9pm; one 4.45pm to 9pm; and one 3pm to 11pm. There is an RN and caregiver for the service over night. There are also ancillary staff and caregivers inform that they help each other across the wings as needed. Interviews with residents and family members identify that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas. All records are signed and dated by the staff member.
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	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs are provided for families and residents prior to admission or on entry to the service. Admission agreements reviewed (for long-term residents) align with all contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a	FA	There are policies and procedures in place for safe medicine management that meet current guidelines and legislative requirements. Staff who administer medications (RNs, enrolled nurse and senior caregivers) have been assessed for competency on an annual basis. Registered nurses have

safe and timely manner that complies with current legislative requirements and safe practice guidelines.		completed syringe driver training. Education around safe medication administration has been provided annually. There is evidence of medication reconciliation on delivery of robotic roll medications against the medication chart with an RN signature on the first robotic roll sachet. All medications are stored safely in the one medication room. The expiry dates of the bulk supply order medications were checked regularly. The medication fridge temperature is checked daily and within acceptable limits. There were no self-medicating residents on the day of audit. Medication chart prescribing meet legislative requirements. Medication charts reviewed (fifteen on the electronic medication system and one paper-based medication chart for the respite care resident) had photo identification and allergy status documented on the chart. The administration sheets corresponded with the medication charts. All medications charts reviewed evidenced three-monthly GP review.
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	The food service is managed by the head chef who is also the lead chef for Bupa. He is supported by qualified cooks, morning and afternoon kitchen assistants. Food services staff have attended food safety training. The food control plan has been verified and expires 22 September 2019. All meals and baking are prepared and cooked on-site in a kitchen located on the ground floor within the service area of the facility. The dietitian reviews the four-weekly seasonal menu six-monthly which reflects resident preferences. The head chef receives a resident dietary profile and is notified of any dietary changes. Resident dislikes are accommodated. Texture modified meals are provided and moulds are used for pureed foods to improve the presentation of pureed meals. Meals are transported in bain maires by the service lift to the kitchenettes in the rest home and hospital dining room. The meals are served by the chef. Fridge, freezer, chiller and cooked temperatures are taken and recorded daily. Perishable foods sighted in the kitchen and facility kitchenette fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. A cleaning schedule and task list is maintained. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to	FA	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.

the consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment booklet on admission including relevant risk assessment tools. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others. InterRAI assessments and assessment notes were in place for the long-term resident files reviewed including the younger person. The long-term care plans reflected the outcome of the assessments (link 1.3.5.2). The respite care resident had a short stay nursing assessment in place (link 1.3.8.2).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Resident care plans in all long-term files were individualised and resident-focused. For five of seven long-term residents, identified assessed support needs were not all included in the care plans. Short-term care plans were in use for changes to health status to guide staff in the delivery of care for short-term needs (link 1.3.8.2). Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. There was evidence of allied health care professionals involved in the care of the resident including GP, physiotherapist, podiatrist, dietitian, district nurses and wound nurse specialist.
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	When a resident's condition alters, the registered nurse initiates a review and if required, GP, nurse specialist consultation. There was documented evidence on the family/whānau record page that family members were notified of any changes to their relative's health status including GP visits, infections, accidents/incidents and medications. Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes and photos as applicable were in place for sixteen residents, including three with facility-acquired pressure injuries (two stage I and one stage III). There is evidenced of district nurse and the DHB wound nurse specialist input in the pressure injuries. A casual RN (interviewed) has been a district nurse and provides wound advice and support as needed to the RNs. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Short-term care plans document appropriate

		interventions to manage short term changes in health (link 1.3.5.2 and 1.3.8.2). Monitoring occurs for weight, vital signs, bowel records, blood sugar levels, pain, challenging behaviour, repositioning charts and food and fluid charts. There was a shortfall identified around neurological observations and restraint monitoring.
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 service employs two activity coordinators to implement the Monday to Friday integrated rest home/hospital activity programme. The team attends two-monthly Bupa training days delivered by an occupational therapist based at head office. A morning programme is held in the hospital lounge and afternoon programme in the rest home. Care staff assist hospital level residents to activities and entertainment of their choice. One-on-one contact is made with residents who are unable or choose not to participate in activities. Activities includes (but not limited to): news and views; exercises including Tai Chi; reminiscing; board games; quizzes; book club; movies and entertainment. Festive occasions and events are celebrated. Community links are maintained with weekly interdenominational church services, school children visits, canine friends a weekly entertainer. There are twice-weekly van outings in the wheelchair access van to the movies, garden centres, parks and shopping trips. A resident activity assessment and Map of Life is completed on admission. Socialising and activities are included in the long-term care plan. The activity coordinators are involved in the six-monthly review. The service receives feedback and suggestions for the programme through surveys and resident meetings. Families are encouraged to be involved in the activity programme, outings and events such as the movie nights. Residents interviewed stated they were happy with the activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	All initial care plans reviewed were evaluated by the RN within three weeks of admission. Care plans had been reviewed by the multidisciplinary team (MDT) that included RN, care staff, GP, physio and any other allied health professionals involved in the resident's care. Family are invited to attend the MDT review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Long-term care plans are evaluated six monthly. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and are evident in changes made to care plans. Short-term care plans are used to document needs and supports for short-term care plans, however, not all short-term care plans sighted had been evaluated. Respite care residents have a short stay nursing assessment on admission. The short stay assessment for the respite care resident had not been reviewed for the last two subsequent respite

		care admissions.
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	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service. There is evidence of the service referring residents for re-assessment for higher level of care.
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	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets are readily accessible for staff. Chemicals were correctly labelled and stored safely throughout the facility. Safety datasheets were readily available to staff. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training provided by the chemical supplier. A chemical spills kit is available. There are two sluice rooms with personal protective equipment available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building is two levels with a service lift for the kitchen and stair access to the four resident rooms downstairs. Residents in downstairs rooms have been assessed as able to manage the stairs. The building has a current warrant building of fitness which expires 3 June 2019. There is a full-time maintenance person who is also a health and safety representative and on the falls committee. He has completed chemical safety and first aid. A maintenance and repair log is maintained and repairs sighted as signed off. There is a planned maintenance plan that includes facility and resident related equipment. Electrical testing and tagging are completed annually on all equipment including electric beds and hoists. Weight scales have been calibrated. Hot water temperatures in resident rooms and communal showers are checked monthly and within acceptable temperatures. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids or transfer of residents using specialised hospital recliners. There is safe access to the outdoor garden and grounds. Seating and shade are provided. Environmental improvements include: refurbishment of resident rooms as they become vacant; renovation of three communal bathrooms; conversion of a

		smaller lounge into a café/coffee shop for residents and their families; refurbishment of rest home dining room; upgrading of furnishings; and raised garden beds for resident gardening activities. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including pressure injury prevention resources.
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	All but one resident room in the rest home has a toilet and basin ensuite. Resident rooms in the hospital have a mix of own or shared toilet and basin ensuites. There are adequate numbers of communal showers and toilets in both the rest home and hospital. All communal facilities have privacy slide signs and shower curtains. The four resident rooms downstairs have full ensuites. Residents interviewed confirm care staff respect the resident's privacy when attending to their personal cares.
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	All rooms are single and spacious. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Hospital rooms have widened doors. Residents and families are encouraged to personalise their rooms. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments.
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	Communal areas in the rest home include a spacious dining room and separate large lounge. There is a large open plan dining/lounge in the hospital area. Activities are held in both lounges where seating is arranged to allow both individual and group activities to occur. There is a smaller lounge that has been converted into a café style lounge. There are seating alcoves throughout the facility. All communal areas are accessible to residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe	FA	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff on duty seven days a week. The laundry and cleaning staff have completed chemical safety training. The laundry is located downstairs, and the dirty laundry is delivered by a shute to spring loaded trolleys in the laundry. A warning bell is

and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		rung before laundry bags are placed into the shute. The laundry has a defined clean/dirty area. The cleaner's trolleys have locked chemical boxes on them and the trolleys are stored in locked cleaners' cupboards when not in use. Internal audits monitor the effectiveness of the cleaning and laundry processes. The chemical supplier conducts quality checks on the effectiveness of washing and cleaning processes. The laundry has a labeller for residents clothing to minimise lost items.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Low	Emergency and disaster policies and procedures are in place. An approved fire evacuation plan is available dated 13 February 2004. Fire evacuation drills take place every six months. The orientation programme and annual education and training programme include mandatory fire and security training. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency stored in a civil defence shed that is readily available to staff in an emergency. There is sufficient food available and adequate water storage in plastic drums. There is a gas barbeque for alternative cooking. A call bell system is in place in all resident rooms, ensuites and communal areas but these are not checked. A minimum of one person with a current first aid certificate is on duty 24 hours a day, 7 days a week. External lighting and security systems are adequate for safety and security.
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, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The residents and family interviewed confirmed the temperature of the facility is comfortable. Four residents' rooms downstairs have opening doors onto a deck. All other rooms have opening windows for ventilation.
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	Harbourview has an infection control programme. The infection control programme, 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 and the Bupa KPIs. An RN is the designated infection control nurse and has access to the DHB infection control nurse and microbiologist. Audits have been conducted and include hand hygiene, infection control practices in the laundry and cleaning service. Education is provided for all new staff on orientation. Staff interviewed stated they had adequate supplies of personal protective equipment (PPE). The infection control programme is reviewed annually by the corporate quality and risk team and the 6-monthly North Island IC committee.

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	An RN is the infection control nurse and is aware of the need to analyse data and the reasons behind this. The infection control nurse receives ongoing education and completed external training 2017. In the event of the infection control nurse requiring advice, this is available through the GP, the DHB resource person or Bug Control.
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 outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection control policies link to other documentation and uses references where appropriate.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control nurse ensures training is provided to staff. Informal education is provided, availability of the education was confirmed by caregivers interviewed. The orientation package includes specific training around hand washing and standard precautions. Training on infection control occurred in July 2017. Hand washing is an annual competency. Resident education is expected to occur as part of providing daily cares.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the

infection control programme.		responsibility of the infection control nurse. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the caregivers and nursing staff confirm their understanding of restraints and enablers. At the time of the audit, the service included five residents using restraints and four with enablers. Restraints included four low bed and one bedrail and enablers included four residents with bedrails. Staff training around restraint minimisation and management of challenging behaviours has been scheduled for 2019 (link 1.2.7.5).
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	Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments for restraint. Family are consulted as part of the authorisation and whether previous advance directives related to restraint are in place. Restraint documentation identifies involvement of family. Individual approved restraint is reviewed at least three-monthly and as part of six-monthly MDT review with whānau involvement.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Bupa policies and procedures provide guidance and process to ensure a robust assessment process prior to the use of restraint. Two residents with an enabler and two with a restraint were reviewed, all had appropriate assessment documented according to Bupa policies.
Standard 2.2.3: Safe Restraint Use	FA	Two resident files were reviewed for use of restraint and two with an enabler. The resident files evidence that consideration to alternatives has been considered in association with the family and GP. Three of four care plans reviewed did not include interventions to support all identified risks related to

Services use restraint safely		restraint (link 1.3.5.2). There was no restraint/enabler monitoring documented for three residents (two on restraint and one with an enabler) (link 1.3.6.1).
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint usage throughout the organisation is monitored regularly and is benchmarked. Review of this use across the group is discussed at regional restraint approval groups. Individual episodes of restraint are reviewed at least monthly as the service works towards being restraint-free as described by the clinical manager and the caregivers. Three-monthly GP reviews and six-monthly MDT also review individual use of restraint.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed as part of six monthly MDT reviews with family involvement and three-monthly GP review. Restraint usage throughout the organisation is monitored regularly and is benchmarked. Review of this use across the group is discussed at regional restraint approval groups. Restraint meetings have not been held at Harbourview in 2018 (link 1.2.3.5).

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	Following a DHB complaint an action plan had been documented. This audit was able to evidence that many of the issues highlighted had been actioned including staffing, meals, medication management, laundry provision, poor care, family communication and access to medical attention. Some aspects of the complaint were not able to be evidenced as addressed including call bell audits, communication to staff through meetings and fully documenting care needs in the resident care plan.	Issues highlighted in a post DHB complaint action plan had not been actioned as per the complaint response	Ensure that post complaint action plans have been fully implemented 90 days

Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	The service has a schedule of meetings and set agendas documented for 2018. Infection control meetings have been held regularly. This schedule has not been fully implemented. The service has reviewed its quality process' and an action plan with a new meeting schedule has been documented. Meetings have commenced according to the new schedule.	For the year 2018, meetings scheduled have not been documented as completed. This included one quality and risk meeting, one health and safety meeting, and no restraint minimisation meetings. Meetings held did not document feedback of quality information including complaints and internal audit results	Ensure that quality, staff and other meetings are completed as per schedule and quality data is communicated through the meeting process. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Bupa has a comprehensive training schedule with associated resources for staff. This schedule was not fully implemented for 2018. The service has reviewed training and has an action plan in place to implement training for all staff.	The Bupa training plan has not been fully implemented for staff at Harbourview. The staff have not completed all compulsory subjects in the last two years.	Ensure that the training schedule is implemented and ensure that staff can access at least eight hours of training. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required	PA Moderate	Resident care plans identified the required needs and interventions to meet resident goals in five of seven long-term resident files reviewed. Short-term care plans had been completed for wounds, infections and short-term needs.	The were no documented interventions for; (i) two residents with unintentional weight loss (one rest home and one hospital); (ii) one rest home resident with pain and swelling of the foot requiring GP intervention; (iii) one rest home resident with shoulder pain requiring GP intervention and analgesia; (iv) one hospital resident (insulin dependent diabetic) did not have a diabetic management plan in place. The same resident did not have documented pressure injury	(i)-(vi)Ensure care plans reflect the resident's assessed needs and supports for their current

support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.		Each file had a care summary in place.	management/prevention interventions in place; (v) the care plan for one hospital resident, did not reflect current decline in mobility and transferring or document the presence of a stage III pressure injury including pressure injury prevention strategies; (vi) the care plans of three residents (one with an enabler and two with restraints) did not document the risks and interventions associated with the use of the restraint/ enabler; and (vii) One file for a resident who identified as Māori did not have this reflected into their care plan	health status. (vii) Ensure that Māori cultural aspects of care are reflected into the care plan 60 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 falls (witnessed and unwitnessed) are documented on an accident/incident form. The RN assesses the resident for any injury and commences neurological observations for unwitnessed falls and falls with obvious injury/bump to the head, however these observations have not always been completed. There are two residents with restraint and one resident with an enabler. The care plan documents the requirement for two-hourly monitoring, however there are no monitoring records to evidence this is occurring.	(i)There were no neurological observations completed as per policy for four out of five unwitnessed falls; and (ii) There was no restraint/enabler monitoring for three residents (two on restraint and one with an enabler).	2) Ensure neurological observations are completed as per policy and 2) Ensure restraint/enabler monitoring is completed as per policy. 60 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused,	PA Low	Long-term care plans are evaluated six monthly. Short-term care plans are used to guide staff in the delivery of care for short-term changes to health such as wounds, infections and pain. However, not all short-term care plans had been evaluated to	(i) Four short-term care plans had not been evaluated to monitor the resident's response and progress against the interventions; and (ii) the respite care nursing assessment had not been reviewed with each subsequent admission to ensure the supports provided continued to meet the resident's needs.	(i)Ensure short-term care plans are evaluated and either resolved or if an ongoing problem added to the long-term

indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.		monitor the residents progress towards meeting their goals. The respite care resident has a nursing assessment completed on admission, however this had not been reviewed for subsequent admissions for changes to their health status and support needs.		care plan; and (ii) Ensure respite care nursing assessment are reviewed with each admission. 90 days
Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.	PA Low	The service has a call bell system in place for all areas of the service. Call bell audits have not been documented	The service has not audited the call bell system following a complaint	Ensure that call cell response times are audited 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.