

Ripponburn Holdings Limited - Ripponburn Home and 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 Q-Audit 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:	Ripponburn Holdings Limited
Premises audited:	Ripponburn Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 September 2019 End date: 27 September 2019
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

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

Ripponburn Hospital and Home provides rest home and hospital level care for up to 46 residents. The service is operated by Ripponburn Holdings and managed by one of the directors as the general manager and a nurse manager. Residents and families spoke positively about the care provided.

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

Areas identified as requiring improvement relate to medication management and testing and tagging of electrical cords and appliances.

Consumer rights

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

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

A resident who identifies as Māori has their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents' admission into the facility is managed and coordinated by the nurse manager and general manager. Relevant information is provided to the potential resident/family prior to admission.

The registered nurses (RNs) and general practitioner (GP), assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

Medication management policies reflect legislative requirements and guidelines.

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

Safe and appropriate environment

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.
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The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Ripponburn home and hospital has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Four restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme (IPC) aims to prevent and manage infections. The programme is led by an experienced and trained infection control coordinator. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. There has been no infection outbreak since last audit.

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	1	1	0	0
Criteria	0	98	0	1	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ripponburn Hospital and Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) when required and the general practitioner makes a clinical based decision on resuscitation authorisation. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record.</p> <p>Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family member's lives.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the advocacy service. Posters and brochures related to the advocacy service were also displayed and available in the facility. Family members and residents spoken with were aware of the advocacy service, how to access this and their right to have support persons of their choice. Staff provided examples of the involvement of advocacy services in relation how to access the service if required such as following a complaint from a resident.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips and other organised activities.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that two complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The general manger is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through discussion with staff and by posters and brochures. The Code is displayed in reception areas together with information on advocacy services, how to make a complaint, "Ideas on how to make your visit more meaningful" brochure for family and visitors and feedback forms.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain resident's privacy throughout the audit. All residents have a private room or share a room with another person with their consent.</p> <p>Residents are encouraged to maintain their independence by community activities, arranging their own visits to the hairdresser, and regular visits by friends and family. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has one resident who identifies as Māori. Cultural support is included in the residents' care plan and includes weekly visits by a Māori cultural support person. The service has a Māori health plan in place which was reviewed. Guidance on tikanga best practice is available by the local Kapahaka coordinators.</p> <p>Staff acknowledge and respect the residents' individual cultural needs. Staff support residents in the service who identify as to integrate their cultural values and beliefs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed (for example religion). The annual resident satisfaction audit confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, palliative care team, wound care specialist, and continuing education programme for staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Other examples of good practice discussed during the audit included the evening reading programme. The organisation reported it has noted a change in residents' behaviour since the programme was introduced such as a reduction of falls and reduced wandering of a number of residents.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all the residents are able to speak English. The service has developed a specific brochure for family and friends when access the service to guide "Ideas on how to make your visit more meaningful" brochure. The nurse manager reported this was well utilised as evidenced by the number that required printing each month.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Ripponburn Hospital and Home is owned by Ripponburn holdings. The general manager (GM) is part owner of Ripponburn Home and Hospital along with other family members. The GM outlined the annual and longer-term objectives and the associated operational plans. A sample of the annual report to the board of directors showed adequate information to monitor performance is reported including, incidents/events, health and safety, infection prevention and control and other emerging risks and issues.</p> <p>The service is managed by a GM who holds relevant qualifications and has been in the role for 15</p>

		<p>years and a total of 27 years' experience. The GM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through membership with the retirement village association (RVA). The GM is supported by an experienced nurse manager (NM) who has been in the position for more than 14 years. The NM is responsible for oversight of clinical care provided to residents and quality activities.</p> <p>The service holds contracts with the DHB for residential care (including under 65years), exceptional circumstances and day care. Fourteen residents were receiving services under the rest home contract, 29 hospital care and one special circumstances at the time of audit. At audit no residents were under 65 years.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the GM is absent, the nurse manager (NM) carries out all the required duties under delegated authority. During absences of key management clinical staff, the clinical management is delegated to the RN on duty, with the support of the NM who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes, management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and a continuous improvement register.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting/quality and risk team meetings and department staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and reports at staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed satisfaction with the service. One resident's family member indicated difficulty finding their way around the facility. The outcome was a map that to give clear directions to all areas.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and</p>

		<p>removal of obsolete documents.</p> <p>The NM described the processes for the identification, monitoring, review and reporting of risks and hazards and development of mitigation strategies for each department. The NM is familiar with the Health and Safety at Work Act (2015) and has the role of the health and safety officer and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at staff and board of directors' meetings.</p> <p>The GM described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, or DHB since the previous audit.</p> <p>As part of the pre-audit, feedback was sought from the DHB and no issues were raised.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements and other relevant education such as stoma care, managing challenging behaviours, dealing with challenging situations, elder abuse and safe cultural practice. The training coordinator is responsible for this with input from the general manager and nurse manager.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. There are four trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual</p>

		performance appraisals.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member in the hospital wing is a registered nurse who provides assistance when required for the rest home wing.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Residents records are hard copy and fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP records. This included interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site within the current clinical files. When required Resident's' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The GM and NM are responsible for managing the admission process. Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) agency. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. A record of all inquiries was kept by the GM and follow up completed as required. The inquiries book was sighted.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner by the nursing team</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>and the GP, with an escort as appropriate. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Ripponburn home and hospital uses a standardised form to facilitate transfer of residents to and from acute care services. The GM reported that there is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. Referrals were documented in the progress notes in the reviewed files. Information related to when a resident's placement can be terminated is included in the admission agreement.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>There was one resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. Documentation of self-medication administration was completed in the resident's care plan, assessment and consent forms were sighted in the resident's file. Regular reviews of self-medication administration were completed every three months. In interview conducted, the resident reported that they were comfortable with the process and they had regular contact with the nurses. Resident's medication was kept secure in the resident's room.</p> <p>There is an implemented process for comprehensive analysis of any medication errors. Corrective actions were implemented for all medication incidents.</p> <p>An improvement is required with regard to the preparation of medication for administration and medication competencies.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>All meals are prepared and cooked on-site by a qualified chef, cooks and kitchen hands, and is in line with recognised nutritional guidelines for older people. The meals are served in the main dining rooms and in residents' rooms if desired by the resident. The menu follows summer and</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>winter patterns and has been reviewed by a qualified dietitian within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by ministry of primary industries (MPI). Food, fridge and freezer temperatures are monitored appropriately and recorded as part of the plan. The chef has undertaken a safe food handling qualification, with cooks and kitchen assistants completing relevant food handling training. The kitchen was clean, the pantry tidy and adequate stock was sighted. Training records were sighted in the documents reviewed.</p> <p>Dietary requirements for each resident are assessed on admission by the admitting RN and a diet profile developed, a copy is sent to the kitchen staff. Residents' personal food preferences, any special diets, allergies, dislikes and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was available.</p> <p>Interviewed residents reported satisfaction with the meals provided. Evidence of resident satisfaction with meals was verified by satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The GM reported that the resident and/or family will be advised of the reason for the decline and will be referred to alternative providers as required.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Initial assessments are completed by the RNs using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and continence, mobility and communication assessments, as a means to identify any deficits and to inform care planning within 24 hours of admission. InterRAI assessments and care plans were completed within three weeks of admission. The sample of care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions in the reviewed files. Residents and families confirmed their involvement in the assessment process.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Changes to residents' needs were documented and communicated to relevant staff as required. Interviewed residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>In the files reviewed, interventions were adequate and appropriate to meet the assessed needs and desired outcomes. Interviews with residents and family verified that care provided to individual residents was consistent with their needs, goals and the plan of care. The interviewed GP verified that medical input is sought in a timely manner, that medical orders are followed, and care is implemented promptly. Interviewed staff confirmed that care was provided as outlined in the care plans. Appropriate equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities assessments are completed with input from the family within three weeks of admission by the diversional therapist (DT). Collected social history data is utilised to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. There are individualised activities plans for each resident that take into consideration residents' needs, age, culture and setting of the service. Residents' activity needs were evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The activities programme is provided by a trained DT, and three activities assistants and covers seven days of the week. There are separate planned activities for rest home and hospital level residents. However, all residents are free to join either side activities if desired, and there are other activities that are combined especially the ones provided by external groups or performers and church services. Individual, group activities and regular events are offered.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Residents and families/whānau were involved in evaluating and improving the programme through residents' meetings, satisfaction surveys and six-monthly multidisciplinary reviews. Residents interviewed confirmed they find the programme satisfactory. The activities on</p>

		the programme include: Bingo, internal quiz sessions, music, newspaper reading, bowls, church sessions, external entertainment, visits from the day care, quiz competitions with other service providers, Tai Chi, RSA afternoon tea, care and friendship sessions where residents go out into the community. The residents were observed participating in a variety of activities on the audit days.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift by care staff and reported in the progress notes. If any change is noted, it is reported to the RNs. The RN's reviews and documents in the progress notes weekly. Evidence was sighted in the reviewed residents' files. Reviewed care plans were evaluated six monthly following the six-monthly interRAI reassessments, or as residents' needs change. Where progress was different from expected, the service responds by initiating changes to the plan of care. Reviewed short-term care plans were consistently reviewed and progress evaluated as clinically indicated for acute infections and wounds. Interviewed RNs reported that, when necessary, and for unresolved problems, long term care plans are updated. Interviewed residents and families/whanau confirmed their involvement in evaluation of progress and any resulting changes through six-monthly monthly multidisciplinary meetings.
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 NM, GM or RNs and the GP facilitates and supports residents to access or seek other health and/or disability service providers as required. The service has contracted GP services through a local medical centre, residents may choose to use other medical practitioners if desired. If the need for other non-urgent services are indicated or requested, the GP or RNs sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to palliative care specialists, wound care specialists and mental health team. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews with family and residents. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
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	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company (Diversity) is contracted to supply and manage all chemicals and cleaning products. They also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision

or hazardous substances, generated during service delivery.		and availability of protective clothing and equipment and staff were observed using these.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The facility was purpose built in the 1930's. A current building warrant of fitness was sighted (expiry date 14th June 2020).</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Calibration of bio medical equipment is current as confirmed in documentation reviewed, and observation of the environment. An improvement is required to ensure that the testing and tagging of electrical appliances is completed in a timely manner.</p> <p>Maintenance is completed in an on-going manner by two employed maintenance personnel. An inspection of the facility confirmed that all maintenance concerns were being addressed. Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>All hazards are identified and monitored accordingly, with any concerns reported to management and discussed at staff and board meetings. Routine environment audits ensure the environment is hazard free, that residents are safe, and independence is promoted.</p> <p>Signs of vermin is monitored with appropriate action taken as required.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes shared bathrooms, en-suites and separate toilets. Each resident room has a handbasin. Equipment and accessories are available to promote resident independence. Hot water temperatures are routinely monitored at the point of use.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Seven residents in the hospital wing share accommodation. Where rooms are shared approval has been sought and staff access the resident's suitability to share. A relative confirmed interviewed being asked for permission. Rooms are personalised with photos and other personal items displayed. Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There is room to store mobility aids and wheelchairs</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> <p>There are no restrictions regarding visiting hours and family interviewed confirming that they are made welcome at any time. The facility provides a sleeping over room for relatives if required.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry area. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. An audit undertaken at the beginning of the year indicated an issue with residents' clothes being returned in a timely manner. The facility developed an action plan to address the issue with one action to clearly relabel all the residents clothing. The following audit indicated increased compliance with clothing being returned correctly in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. This was confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 1st May 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the number</p>

		<p>of residents. There is a water storage tank and a generator on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call bell system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Heating is provided by radiators in the corridors and in the communal areas providing a thermostatically controlled heating throughout the facility and ensuring temperatures can be monitored. The facility has plenty of natural light and ventilation. Each bedroom has an external window of normal proportions. There are no residents or staff that smoke on the premises. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Ripponburn home and hospital has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from specialist services. The infection control programme and manual are reviewed annually.</p> <p>The training coordinator is the designated infection control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the GM, and tabled at the quality improvement committee meeting. This committee includes the GM, NM, the health and safety officer, DT and representatives from food services and household management.</p> <p>There is a notice at the main entrance to the facility requesting anyone who is or has been unwell in the past 48 hours with an infectious condition, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> <p>Residents and staff were offered the influenza vaccine through the GPs.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>The ICC has appropriate skills, knowledge and qualifications for the role. The ICC is a member of the infection control nurse's college, has completed external training in infection prevention and</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>control and attended relevant infection control study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the local DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC and interviewed staff confirmed the availability of resources to support the programme and any outbreak of an infection. There have been no notifiable infection outbreaks reported since the last audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in November 2018 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection control education is provided by the ICC. Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance was completed. When there was an increase in infection incidence, there was evidence that additional staff education has been provided in response. An example of this occurred when there was an increase in chest infections.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluid intake when urinary tract infections were noted.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, eye, gastro-intestinal, the upper and lower respiratory tract, gastro-intestinal and multi resistant organisms. The infection surveillance was carried out as</p>

<p>in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>specified in the infection control programme. The ICC reviews all reported infections with support from the NM and RNs and these are documented. New infections and any required management plans are discussed at shift handovers, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported in the quality improvement committee meeting.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Ripponburn home and hospital's restraint policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The NM is the restraint coordinator. In the interview conducted, the NM demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities as the restraint coordinator.</p> <p>On the days of audit, four residents were using restraints and no residents were using enablers. The restraints in use were bedrails and lap belts.</p> <p>The restraint coordinator and the staff reported that restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and files reviewed.</p>
<p>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.</p>	<p>FA</p>	<p>The restraint approval group made up of the GM, NM, GP and health and safety coordinator are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the restraint coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed three-monthly.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Restraint consent forms were sighted in residents' files. The use of restraint was documented in the care plans reviewed.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of this standard. The initial restraint use assessments are completed by the RNs with the involvement of</p>

<p>assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>the restraint coordinator, resident, family/EPOA where appropriate. In interviews conducted, the RNs and the restraint coordinator described the documented process. Families confirmed their involvement in the assessment process and plan of care. The GP was involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause of the behaviour or condition where applicable, history of restraint use, cultural considerations, alternative methods trialled and associated risks. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of residents who were using restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints was reviewed and evaluated during care plan, interRAI reviews, three- and six-monthly restraint evaluations, and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of this standard, including future options to eliminate use, the impact and outcomes achieved. Restraint audits were completed, and corrective action plans were implemented where required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The quality improvement committee undertakes a three-monthly review of all restraint use which includes all the requirements of this standard. Individual restraint use is reported in the quality and staff meetings every two months. Minutes of meetings reviewed confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered and the effectiveness of the restraint in use. Restraint use competency assessments for staff were completed annually, current restraint competencies were sighted in reviewed staff files. Restraint use internal audits also informed these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated as reported by the restraint coordinator in the interview conducted.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policy is current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management.</p> <p>The GPs prescribes medication and all prescription charts reviewed had current three-monthly medication reviews completed consistently. Dates for commencement and discontinuation of medicines and all requirements for (PRN)</p>	<p>Not all medication requirements have been maintained. For example, medication is being decanted into medicine cups and stored in the medication trolley and some medications are being crushed without evidence of approval.</p>	<p>Discontinue decanting medication and provide evidence of approval to crush medications.</p> <p>90 days</p>

		medicines were documented. Allergies were documented and current residents' photos were in place for easy identification of residents.		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>All staff who administer medicines have current medication administration competencies. However, these competencies were signed off by staff who do not have current medication administration competency.</p>	<p>Not all staff have the required competencies.</p>	<p>Provide evidence that medication administration competencies for all RNs are current.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>Inspection of electrical cords and appliances was noted not to be current. The facility has arranged for this to be completed at the end of October prior to audit therefore the risk rating has been reduced to low.</p>	<p>A number of electrical cords and appliances testing, and tagging was not current (expiry early September 2019).</p>	<p>Ensure all testing and tagging of electrical cords and appliances is completed in a timely manner</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.