

Heritage Lifecare Limited - Carter House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Carter House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 1 October 2019 End date: 1 October 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:	64

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Carter House provides rest home, hospital and dementia care services for up to 65 residents. The service is operated by Heritage Lifecare Limited and managed by a care home and village manager, a clinical service manager and a quality manager. Residents and family spoke positively about the care provided.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers and staff. The general practitioner was not available for interview.

This audit resulted in no identified areas identified as requiring improvement.

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.	Green	Standards applicable to this service fully attained.
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There are effective communication systems between staff, between staff and residents and their families and with other health providers. The service adheres to the practices of open disclosure where necessary.

Review of complaint records and interviews with staff, residents and families demonstrated that complaints received since the previous audit has been managed effectively. The Office of the Health and Disability Commissioner (HDC) are in the process of investigating a complaint from 2018.

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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The service is maintaining its quality and risk management system with regular monitoring of all service areas.

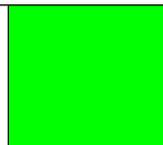
Adverse events are reliably reported by all levels of staff. There is evidence that people impacted by an adverse event are notified for example, general practitioners and families. Notification of serious events is occurring as required by regulatory requirements.

Human resources systems are in place and staff are recruited and managed effectively. Staff training in relevant subject areas is occurring regularly. All staff are supported and encouraged to attend ongoing performance development and achieve educational qualifications in health care.

There are adequate numbers of skilled and experienced staff on site to meet the needs of residents 24 hours a day seven 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.



Standards applicable to this service fully attained.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

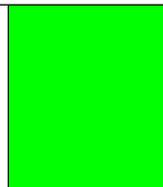
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

Nutritional meals, snacks and fluids are provided in line with recognised nutritional guidelines. Special dietary requirements are catered for. Residents verified satisfaction with meals provided. The service has a food control plan.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

Carter House has a current Building Warrant of Fitness. All building regulations, fire safety, emergency and security standards are met. Residents and families interviewed were satisfied with the environment.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint systems and practices meet the requirements of this standard. On the day of audit there was one resident who required positioning in a fall out chair for safety reasons and one resident who used bed rails voluntarily. Assessment, consent, approval and monitoring and review occurs in relation to the use of these interventions.

Staff training on restraint and enabler use is being provided regularly.

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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Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	39	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service is maintaining a complaints register and effectively managing the complaints process. Residents and family members interviewed demonstrated knowledge and understanding about how to raise a complaint. Interview with the care home manager and review of the documentation related to the seven complaints logged in 2019, confirmed that each matter was investigated immediately and managed effectively for resolution with all parties. There was evidence of ongoing communication with all people involved and external advocacy had been offered where necessary.</p> <p>A complaint submitted to the Office of the Health and Disability Commissioner in 2018 which was related to pressure injuries, is still under investigation.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>The open disclosure policy clearly and accurately describes the principles of open disclosure and how to implement this when required.</p> <p>Family members interviewed confirmed they are kept informed of the resident's status and are notified of adverse events. Contact with the family is documented if the resident has been involved in an incident/accident or there has been any change in the resident's condition. Details from doctors' visits are documented and communicated as required.</p>

communication.		Staff said they knew how to contact interpreter services if required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The Care Home Manager (CHM) is an RN with relevant qualifications. The CHM commenced at Carter House January 2019 and has long term experience in the NZ health sector as an RN and has had previous clinical manager experience in aged care facilities manager in aged care facilities, needs assessment coordination and assessment and as interRAI educator. Responsibilities and accountabilities are defined in this person's job description and individual employment agreement. The care home manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through regular meetings with the DHB and other age care facility managers.</p> <p>Carter House has agreements with the DHB for age related care (ARCC) in rest home, dementia, hospital (medical and geriatric care) respite/short stay and day services and Long Term Services, Chronic Health Care (LTS-CHC).</p> <p>On the day of audit 64 of the 65 beds were occupied. Twenty residents were receiving rest home level care and 25 plus one respite resident were receiving hospital level care. There were 17 residents in the secure unit. One hospital resident under 65 years of age was being care for under the LTS-CHC agreement.</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 the management of complaints, internal audits across all areas of service delivery and monitoring of outcomes, resident and relative satisfaction surveys and the reporting and collation of adverse events such as accidents/incidents, pressure injuries, restraint interventions and infections.</p> <p>The organisation (HLL), uses the same system for each of its facilities to report their quality data for example, number of falls with or without injury, medicine errors, pressure injuries, restraint, urinary tract infections, bruising and skin tears, and staff incidents. This data is collated by a dedicated quality coordinator who conducts a monthly analysis looking for trends and ensuring that actions are underway to remedy any unwanted trends. This is then submitted to HLL's national office who produce a monthly quality indicator report which shows how the facility compares with other services and whether they are over or under the benchmarked target in each category. Where gaps or deficits in service delivery are identified corrective actions are developed and implemented to address any shortfalls.</p> <p>Information from quality monitoring is shared with staff at regular monthly meetings and written information was observed to be on display in staff areas. The staff interviewed confirmed that they are kept well informed and may also be involved in quality and risk management processes through internal audit activities, quality projects and acting as representatives for health and safety.</p> <p>Resident and family satisfaction surveys are completed annually. Results from the most recent 2019 survey</p>

		<p>showed no major issues or areas of concern.</p> <p>Policies and procedures are controlled and managed nationally to ensure a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Policies are based on best practice and cover all aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process.</p> <p>The care home manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There had been no staff injuries requiring notification to Worksafe NZ.</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 incident forms reviewed for 2019 revealed clear descriptions of the event and evidence of notifications to people impacted by the incidents. For example, family, the manager on call and/or the GP. All incidents were being reviewed and investigated by the CSM, to determine cause and effect and what if any type of actions require follow-up. There was evidence that actions are monitored for implementation. Consequential actions are recorded in the resident's electronic progress notes. Adverse event data is collated, analysed and reported to staff as described in standard 1.2.3.</p> <p>The care home manager understands and adheres to the requirements for essential notification reporting, including for pressure injuries. The records showed appropriate notifications of significant events made to the Ministry of Health, in 2019. Examples included reports of missing residents with police involvement, five stage three pressure injuries (three of which were present when admitted) and a gastro-enteritis outbreak which was also notified to local public health officers in June.</p> <p>There have been no coroner's inquests, or issues-based audits.</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</p>	FA	<p>Staffing policies and practices 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 six 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 followed by an initial performance review.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff</p>

<p>legislation.</p>		<p>have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Records reviewed demonstrated that eight of the 28 caregivers have completed level 4 or higher of the National Certificate in Health and Wellbeing (or its equivalent). Eleven carers have achieved level 3, one has achieved level 2 and eight are at level one. Interviews and documents confirmed that each of the staff who are rostered to work in the secure/dementia unit have either completed or are progressing educational achievements in dementia care (US 23920-23923).</p> <p>Nine of the 10 RNs employed are maintaining annual competency requirements to undertake interRAI assessments.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels are adjusted 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.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence.</p> <p>At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage in the facility. Only staff who have completed or are progressing educational achievements in dementia care (US 23920-23923) are rostered for duties in the secure unit.</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>FA</p>	<p>The staff observed administering medicines demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Current medication administration competencies were sighted for all staff who administer medication.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription when medication is received from the pharmacy. All medications sighted were within current use by dates. The service has implemented an electronic medication management system. Staff have completed relevant training for the new system and other topics required for medicine management as per the training records.</p> <p>Interviewed staff demonstrated knowledge on controlled drugs management and storage requirements and are guided by the medication management policies and procedures when required. Controlled drugs checks occur every Tuesday and the contracted pharmacist performs six monthly audits and these were recorded.</p>

		<p>The required three-monthly medication review was consistently recorded on the medicine chart by the GP. On the reviewed medication charts, dates were recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were met. Monthly reviews/audits are completed from the electronic system utilised and reports were sighted.</p> <p>There were no residents self-administering medicines. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by one chef and a relieving cook and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows a four weekly cycle pattern. The service has a contracted dietician who has audited the menu plans within the last two years.</p> <p>Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the food safety plan. The chef interviewed have undertaken a safe food handling qualification. Kitchen hands have also completed all relevant training and certificates are displayed. The chef is responsible for the ordering of all food, checking off all deliveries, temperature monitoring of all foods, fridges and freezers. Records were well maintained.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Food allergies are documented and included in the care plan.</p> <p>Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meetings minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>The service has a current food control plan which expires 19 December 2019. This is displayed at the entrance to the facility.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident. The GP medical records verified that medical input is sought in a timely manner that medical orders are followed, and care is implemented as required. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care</p>

<p>services in order to meet their assessed needs and desired outcomes.</p>		<p>provided and in accordance with the residents' needs. Interviewed residents and families confirmed satisfaction with the care provided.</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 programme is provided by four staff; two are diversional therapists holding national certificates in diversional therapy and two are activities coordinators. All are experienced in providing appropriate activities for all residents. Monthly activities are planned separately for the three streams of residents at this home. Family members are welcome and encouraged to be involved with the activities provided. A weekly programme is displayed in all service areas. The activities staff are allocated residents on admission and are responsible for the initial social assessment and the individual recreational plans and updates as required. The interests, abilities and social requirements are taken into consideration when developing the individual plans. The plans are reviewed when the care plans are reviewed six monthly.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual and group activities and regular events are offered. Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings (minutes of meetings were reviewed), and satisfactory surveys. Residents interviewed confirmed they find the programme interesting and motivating. Van outings in the community with designated drivers are popular for residents as seen on the day of the audit.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the residents living there. Activities are offered at times when residents are most physically active and or restless. This includes activities planned between 6am and 6am (24 hours) on the activities plan sighted. Resources are available for the care staff to access as required. Family interviewed appreciated the activities provided for their relatives and stated there was always and activity in progress for the residents to be involved as able.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes by the care staff. If any change is noted, it is reported to the RNs. The RNs review and document in the progress notes when there is need or changes in residents' conditions and weekly as a minimum. One of the senior registered nurses discussed the Carter House schedules for the RN primary nurses to complete the interRAI assessments, lifestyle care plans and to ensure the dates for the GP reviews are planned. The interRAI assessments were up-to-date.</p> <p>Care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessments, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated for acute infections and wounds in the reviewed files. Unresolved problems were added to the long-term care plans after three weeks. Residents and families/whānau interviewed confirmed involvement in evaluation of progress and any resulting changes. The family communication records evidenced that family are notified when a resident's condition changes or when any issues arise. Short term</p>

		care plans were closed off when the short-term problems have been resolved.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 29 November 2019) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. There have been no structural changes to the building. Improvements to the internal and external environment were observed, for example, replacement of flooring, painting, new furniture and general enhancements for the benefit of residents.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The ICC reviews all reported infection, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. The clinical indicator monthly summary was reviewed. Information is sent through to the organisation's support office and quality staff produce graphs that identify any trends and/or any comparisons with the previous month or year for the surveillance programme. Results of the surveillance programme are then shared with staff via regular staff meetings and at staff handovers. Data is benchmarked externally with the other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator was not available for interview. The CSM explained the process for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice. Staff education on restraint minimisation is ongoing.</p> <p>On the day of audit, there was one hospital resident who needed to be positioned in a fall out chair for safety reasons but could not consent to this and one resident using bed rails voluntarily as an enabler. Restraint is used as a last resort when all alternatives have been explored. This was evident from the review of documents, observations on site and interviews with staff.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.