

Lakeside Lodge Rest Home Limited - Lakeside Retirement Lodge

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 BSI Group New Zealand Ltd, 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: Lakeside Lodge Rest Home Limited

Premises audited: Lakeside Retirement Lodge

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 5 November 2020 End date: 6 November 2020

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 29

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

Lakeside Lodge provides rest home level care for up to 30 residents. On the day of the audit there were 29 residents.

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

The rest home is owned and operated by the facility manager and the clinical manager. Both owners are registered nurses. They employ an additional registered nurse. The rest home continues to have a high registered nurse to resident ratio with stable staffing.

The residents, relatives and general practitioner spoke highly of the care and service provided at Lakeside Lodge. The service has a well-established quality system that identifies ongoing quality improvement.

The one shortfall identified as part of the previous audit around care plan documentation has been addressed. .

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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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and family interviewed verified ongoing involvement with the community.

Organisational management

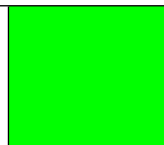
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There is an established quality and risk management system in place that is being implemented. Quality management processes are reflected in the business plan and risk management plan, objectives and policies. There is a monthly staff meeting that includes health and safety, infection prevention and control, discussion of quality and risk matters including adverse events.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

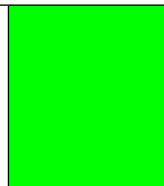


Standards applicable to this service fully attained.

Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

The building holds a current warrant of fitness. Internal areas are spacious warm, and comfortable. External areas are safe and well maintained with shade and seating available. Systems and supplies are in place for essential, emergency and security services.

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 policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. At the time of the audit, the service had no residents using restraints or enablers. Staff have received training around restraint minimisation and management of challenging behaviours.

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 is suitable for a facility of this type. The programme is led by the manager with support from the clinical manager and the registered nurse. The programme is based upon a clear set of policies and procedures that are available to guide staff. The general practitioner is actively involved in the management of residents with suspected infections. Education is provided to staff on an ongoing basis and infection prevention and control is included in the internal audit programme. Infections are monitored, and practice is reviewed every month. Trends can then be identified. There have been no recent outbreaks of infection in the rest home.

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	17	0	0	0	0	0
Criteria	0	43	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>There is a complaints policy and procedure in place, which meets the requirements of the Code. The process is communicated to residents and their families on admission. Complaint forms are readily available. Staff are educated on the complaints process. There have been no complaints made in 2017, 2018 and 2019 and 2020 year to date. Any resident concerns are actively addressed by the managers. Four residents and family members interviewed advised that they are aware of the complaint's procedure. Five staff members and two managers interviewed were able to explain the complaints process.</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>There is a policy to guide staff on the process around open disclosure. The owner/ manager and clinical manager confirmed family are kept informed. Two relatives interviewed stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives sign a communication sheet to inform the service when and under what circumstances they would like to be informed. Ten incident forms reviewed identified that family were notified following a resident incident.</p>

communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Lakeside Retirement Lodge provides care for up to 30 rest home level residents. On the day of audit there were 29 residents. All residents were being provided with services under the Aged Related Residential Care agreement (ARRC).</p> <p>The owner/manager is a registered nurse with a background in mental health. He has worked in aged care since 1996 and has co-owned Lakeside Retirement Lodge for over 17 years. His wife and co-owner is also a registered nurse and is the clinical manager. They both hold current practising certificates.</p> <p>The philosophy, mission, scope and goals of the service are documented in the quality manual and in the information pack that is provided to residents and their families during their admission to the rest home. There is a 2019 to 2020 business plan. There is a quality and risk plan in place developed by a consultant and personalised to Lakeside. The plan aligns to the purpose, mission and values of the business. The manager and the clinical manager have maintained at least eight hours annually of professional development activities related to managing a rest home.</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>Lakeside retirement lodge has a well-established and comprehensive quality and risk programme.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.</p> <p>Monthly staff/quality meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include trend analysis. The staff interviewed were aware of quality data results, trends and corrective actions. The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified as evidence through a review of staff / quality meeting minutes.</p> <p>There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. A monthly summary of internal audit outcomes is provided to the staff/ quality meetings for discussion. Corrective actions are developed, implemented and signed off.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The owner/manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>The service has detailed emergency plans covering all types of emergency situations including a pandemic and</p>

		<p>outbreak plan and staff receive ongoing training around this.</p> <p>Falls management strategies include assessments after falls and individualised strategies. There is ample equipment to assist resident mobility. Each resident has their own walking frame as needed, and there are at least twelve more walking frames stored. Wheelchairs are available and maintained in good order.</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>The service collects all incident and accident information reported by staff on a paper-based system. Incident and accident data is collected and analysed monthly and are reported at the monthly quality/staff meeting. Ten resident-related, incident forms were reviewed for September/ October 2020. Each event involving a resident reflected a clinical assessment and follow-up by an RN. Care staff interviewed were very knowledgeable regarding the care needs (including high falls) for all residents. Discussions with the owner/manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. This has not been required.</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>There are human resources policies to support recruitment practices. The register of RN's practising certificates and allied health professionals is current. Six staff files were reviewed (two RNs, three caregivers and one cook). All files contained relevant employment documentation including current performance appraisals and completed orientations. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>There is a comprehensive annual training schedule. The implemented training schedule included mandatory training as well as additional training as needed. Training for 2020 included pressure injury prevention, more recently the use of PPE, Covid-19 and hand hygiene have also been provided.</p> <p>The two owners (manager and clinical manager) are interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	FA	<p>The manager (RN) and clinical manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. An RN covers Saturday and Sunday morning shifts, one weekday afternoon shift and one morning shift each week.</p>

<p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>There are three caregivers on morning shifts (all full shift), two on the afternoon shift (full shift) and two on night shift. An activities coordinator is rostered Monday to Friday, four to five hours a day.</p> <p>A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are always replaced when off sick. The RN reported additional staff are rostered if the acuity increases,</p> <p>Interviews with residents, relatives and staff confirmed that staffing levels are sufficient to meet the needs of residents. The service does not use agency staff.</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>There are policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders in use. There are no vaccines stored on site.</p> <p>All residents have individual paper-based medication orders with photo identification and allergy status documented. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Medication orders include indications for use of 'as needed' medicines. Short-life medications (i.e., eye drops and ointments) are dated once opened.</p> <p>Administration sheets sampled were all appropriately signed for ten medication charts reviewed. Medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A senior caregiver was observed administering medications and followed correct procedures.</p> <p>Fridge and room temperatures are recorded and are within set temperature ranges.</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 service continues to cook all meals on site by one of two cooks; one works four days and the other, three. There is a kitchenhand on each morning shift. There is also an afternoon cook who works 1200 - 1800. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and meals are served directly from the kitchen to the dining room in bain maries. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures have been monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The food control plan has been verified until April 2021.</p>

		<p>The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by a contracted dietitian. All residents and family members interviewed were very satisfied with the meals.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions document detail around support needs and provide guidelines for care. Care plan sampled included a resident with falls, a resident with a wound, a resident who required insulin / diabetes management, a resident with weight loss and a resident who had mental health input into care. All care plans reflected resident needs, this is an improvement from the previous audit. Short-term care plans are in use for changes in health status. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, wound care specialist and mental health care team for older people.</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>	FA	<p>All five care plans reviewed included interventions that reflected the resident's current needs. When a residents' condition changes the RN initiates a GP visit or specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Registered nurses were regularly involved in resident daily care and ongoing assessments as identified in the progress notes.</p> <p>Continence products are available and resident files include bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by staff interviewed. Staff interviewed stated there is adequate continence and wound care supplies.</p> <p>The service had one resident with a wound documented, there were no residents with a pressure injury. A wound assessment, management plan and regular evaluations were documented.</p> <p>Caregivers reported that a range of equipment was readily available as needed including hoists and manual handling equipment. Caregivers reported that equipment was made available as needed.</p> <p>Monitoring charts were well utilised, and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required.</p> <p>All residents had an advanced directive in place with regard to resuscitation status as evidenced through five resident files reviewed plus to further (just for advanced directives).</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>There is one activities coordinator who works four to five hours a day Monday to Friday, the activities coordinator (a non-practicing RN) described the service as ‘one big happy family’. There is a volunteer who comes in at weekends to play the piano. The activities coordinator also leaves out games and puzzles. On the days of audit residents were observed going for walks, listening to music and entertainers and playing games.</p> <p>There is a weekly programme on a whiteboard in the lounge. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents’ needs. These include exercises, games, quizzes, music and walks outside.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. The activities coordinator visits each room first thing each morning.</p> <p>Church services are provided. There are van outings weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Fathers’ Day, Anzac Day and Chinese New Year are celebrated.</p> <p>The facility has two cats, ducks on the pond and the activities coordinator brings in miniature ponies and other animals to visit.</p> <p>There is community input from volunteers, schools, pre-schools, the RSA, a Kapa Haka group and the Wesley college cultural group.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Resident meetings are held monthly. Residents stated the activity programme was varied and they enjoyed it.</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>The resident care plans had been evaluated by the registered nurses six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three-monthly reviews by the GP for all residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 24 May 2021. The manager is in charge of all</p>

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>maintenance. There is a preventative and reactive maintenance programme. Contractors are used when required. The gardener is contracted.</p> <p>Electrical equipment has been tested and tagged. There are stand on scales. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. There is a mixture of carpet and vinyl flooring throughout the rest home. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is a large pond and stream on the property, all safely fenced. All outdoor deck and courtyard areas have seating and shade. There is safe access to all communal areas.</p> <p>Caregivers interviewed stated they have adequate equipment to safely deliver cares.</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>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Any resident who is suspected of having an infection is reviewed by a registered nurse and the general practitioner. Specimens are taken as appropriate and sent to the laboratory and a record of this action is maintained in the resident's clinical record. Results are received, considered and documented. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Trends are identified, and quality initiatives are discussed at staff meetings (minutes sighted). The rest home has continued to maintain a low infection rate since the previous audit. There are handwashing facilities available for staff and paper towels are used. The GP reviews antibiotic use at least three-monthly with the medication review. There have been no outbreaks.</p> <p>Training around Covid- 19 has been provided, including donning and doffing personal protective equipment (PPE). The service had no admissions during lock down. There is a Covid – 19 plan in place. The service also ensured that the staff did not need to go to the supermarket as all their household food was ordered online for them.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers. There were no residents requiring the use of a restraint or an enabler at the time of audit. Staff receive training around restraint minimisation. All staff are aware that Lakeside Lodge aims to continue their restraint free status.</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.