# Amberley Resthome 2013 Limited - Amberley Resthome and Retirement Village

## Introduction

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

The audit has been conducted by 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Amberley Resthome 2013 Limited

**Premises audited:** Amberley Resthome and Retirement Village

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 17 March 2021 End date: 18 March 2021

**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:** 19

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Amberley Resthome and Retirement Village (also referred to as Amberley Rest Home by the service provider) provides rest home level care for up to 21 residents. Twelve of the beds sit within studio units that are extensions to the rest home hallways. These are each owned under an Occupational Right Agreement and all but one have residents who have been assessed as requiring rest home level care.

The service is privately owned and operated by a facility manager and their partner. A clinical manager assists the facility manager in the day to day operations. Positive feedback about the services provided was consistently provided by residents and family members interviewed.

This certification 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, staff, and a general practitioner.

An aspect of the evaluation of long-term care plans has been 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. |  | Standards applicable to this service fully attained. |

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.

Residents who identify as Māori would have their needs met in a manner that respects their cultural values and beliefs. There was 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.

Information on how to make a complaint is readily available. A complaints register is maintained, which confirms complaints are 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. |

A business plan, a quality and risk management plan and associated documentation include the scope, philosophy, goals and direction of the organisation. Systems are in place than enable ongoing monitoring and review of the services provided. An experienced and suitably qualified person manages the facility with support from appropriate consultants.

The quality and risk management system includes 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 are identified and mitigated. Health and safety systems are in place and relevant monitoring occurs. Policies and procedures support service delivery. These were current and are reviewed regularly.

Recruitment processes, new staff orientation and staff management practices are based on current good practice. Staff are provided with ongoing professional development options with a move to increasing staff access to on-line learning opportunities that support safe service delivery. Individual performance appraisals are completed annually and provide staff with feedback and direction. 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 low risk. |

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

The multidisciplinary team, including a registered nurse and diversional therapist assess residents’ needs on admission. The general practitioner provides assessments within 48 hours of admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Short term care plans and activities plans are evaluated. Files reviewed demonstrated that the care provided and needs of residents are reviewed on a regular and timely basis. Residents are referred 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.

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. |  | Standards applicable to this service fully attained. |

Waste and hazardous substances are managed safely. Chemicals, soiled linen and equipment are safely stored. Staff use protective equipment when applicable, which is readily available.

The facility meets the needs of rest home residents. It has a current building warrant of fitness and is being well maintained. Electrical equipment is tested as required, hot water temperatures are checked for safety and bio-medical equipment calibration was up to date. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Laundry is undertaken onsite, and the facility was clean. Both of these activities are evaluated for effectiveness.

Staff are trained in emergency and fire evacuation procedures and the use of emergency equipment and supplies. Residents are satisfied with staff response timeframes to call bells. Security is monitored and maintained.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

The organisation has implemented policies and procedures that support the minimisation of restraint. Staff are trained in de-escalation techniques and in restraint and enabler use. There were no enablers or restraints in use at the time of audit.

## Infection prevention and control

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

The infection prevention and control programme, led by an experienced infection control coordinator, aims to prevent and manage infections. The programme is reviewed six monthly. 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.

## 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 | 44 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 1 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Amberley Rest 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. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | 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. 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. Staff were observed to gain consent for day to day care. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Brochures are provided to those enquiring prior to entry. During the admission process, residents are given another copy of the Code, which also includes information on the Advocacy Service, and this is discussed with them. Brochures related to the Advocacy Service were available in the facility.  Family members and residents spoken with were aware of the Advocacy Service and of how to access this and their right to have support persons. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are 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, activities, and entertainment.  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. The registered nurse explained the family members are able to participate in any aspects of care as able and desired for their loved one. This was observed during the audit. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints and compliments 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 were clear about how to make a complaint and who to speak with. Copies of complaint forms, the Code, brochures on the advocacy service and a complaints/suggestions box were viewed near the front reception area.  Complaints are entered into an electronic system and subsequently into an electronic complaint register. The complaints register reviewed showed that two complaints have been received over the past year and that actions taken are documented and completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible. One of the complaints was complex and despite evidence confirming efforts to ascertain the level of satisfaction of the complainant, these have not been responded to. The facility manager 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. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and through discussion with staff. The Code is displayed on the noticeboard in the hallway, with information on advocacy services in the foyer and how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents 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 privacy throughout the audit. All residents have a private room.  Residents are encouraged to maintain their independence. Care plans included documentation related to the resident’s abilities, and strategies to maximise independence.  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.  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. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Staff support residents and whānau in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | 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. Family members verified that they were consulted on their individual culture, values and beliefs and that from what they hear and see, the staff respect these. An interdenominational service is held within the facility each month. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | 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. The registered nurse has 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 | The service encourages and promotes good practice through input from external specialist services and allied health professionals, especially the gerontology nurse specialist and the palliative care nurses with whom there is open communication whenever needed. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.  Other examples of good practice observed during the audit included good communication of staff with residents, ensuring residents were happy and comfortable and providing immediate attention if there was anything they could assist with. Staff support and encourage if chosen, a high level of family, whānau involvement was observed during the audit. The activity programme is diverse and involves residents at both individual and group level. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/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.  The facility manager and clinical manager stated they know how to access interpreter services, although reported this was rarely required as all residents currently spoke English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Amberley Rest Home is owner operated by a married couple, one of whom is in the role of facility manager. The facility manager described daily business debriefs with their partner, who also visits the facility at least weekly, and the close relationships both share with a lawyer and an accountant who they meet monthly. A Business Plan 2020 – 2021 notes Amberley Rest Home provides a mix of 9 rest home and 12 studio residents. The philosophy of the service provider is described as being around promoting a quality lifestyle for the Amberley Rest Home residents in a supportive environment and encouraging residents to maintain independence in a safe comfortable care setting. All residents are to be treated as individuals and shown patience, dignity and respect. A Strengths Weaknesses, Opportunities and Threats (SWOT) analysis was completed and five objectives and strategies are outlined.  The facility manager has been in their role at Amberley since 2013 after previously being second in charge of another facility. Responsibilities and accountabilities are defined in a role description and individual employment agreement, which are in a personnel file that was reviewed during the audit. Records sighted confirmed the facility manager’s reports that the operators are supported professionally by a range of advisers including industry, quality management and clinical support. The facility manager undertakes ongoing professional development, has a current performance appraisal and is affiliated with a range of aged care associations and support networks. A facility coordinator and a clinical manager provide direct support to the facility manager.  The service provider has signed an Age-Related Residential Care Services Agreement with the Canterbury District Health Board to provide rest home care. Amberley Rest Home is certificated to provide care for up to 21 residents. On the day of audit, 18 residents were receiving rest home level care. A 19th person was receiving hospital level care (palliative) within the facility and a Notification for One Hospital-level Resident in a Rest home service area (NOHRRA) form had been completed as required. One other person was in the public hospital and there was one empty bed. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The facility coordinator takes over management administration tasks when the facility manager is temporarily absent. Some tasks are handed over to the quality consultant who oversees implementation of the quality and risk management system at the Amberley Rest Home.  A casual registered nurse, who is a clinical manager in another aged care facility and is experienced in the sector, relieves the clinical manager in their absence. The enrolled nurse would continue to be available. Registered nurses from the nearby Amberley Medical Centre who are familiar with the residents are also available to assist when necessary.  All staff interviewed reported the current arrangements work well and there is always a suitable person available to answer any enquiries and address any concerns. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. A quality consultant provides ongoing support and access to electronic monitoring systems to facilitate quality assurance and quality improvement processes. Quality and risk related activities of incident management, complaints, internal audits, monitoring of outcomes, clinical incident reporting, infection prevention and control and feedback processes are being reported and discussed at staff meetings held every two to three months. Meeting minutes reviewed confirmed regular review and analysis of the quality indicators.  All staff interviewed demonstrated a familiarity with the quality and risk system and informed they are actively involved in the related discussion at staff meetings. They are also involved in the development and implementation of applicable corrective actions, especially those related to shortfalls in service delivery. Internal audits are completed by senior healthcare assistants as well as the manager, facility coordinator and the clinical manager. Results are reported through staff meetings and corrective actions developed as indicated. A 2020 staff survey was completed with overall satisfaction expressed. According to staff interviewed and some residents, the annual resident satisfaction survey was reportedly completed in the latter half of last year; however, copies of these could not be found and nor was an update found in meeting minutes. Results of a food satisfaction survey were viewed and over 60% of respondents were fully satisfied. A dining room concern has been addressed and several suggested additional menu possibilities are being passed on to the dietitian for consideration with the next menu review due mid-2021.  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 were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  A risk management plan and associated risk register are reviewed at least annually. All staff and managers interviewed described their responsibilities in relation to the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager and facility coordinator are familiar with the Health and Safety at Work Act (2015) and requirements are being implemented. Risk management and health and safety processes are agenda items of staff meeting minutes. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse and near miss events on an accident/incident form in an electronic format. When an incident occurs out of hours, health care assistants contact the facility manager, the clinical manager or the facility coordinator. 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 from incident reports is auto-populated into an analysis section of the computer, which is compared with the previous twelve months and graphs are developed. The outcomes of analysis of incident reports is presented to staff meetings and opportunities for improvements are identified and discussed. Meeting minutes and interview with the facility manager confirmed reports of these processes.  The facility manager described essential notification reporting requirements, including for pressure injuries, significant injury, any policy investigation and changes in governance. They advised that other than a change of clinical manager, and the recent NOHRRA, there have been no notifications of significant events made to the Ministry of Health since the previous audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources management policies and processes are based on current good employment practice and relevant legislation. The recruitment process includes a formal application process, a one on one interview, 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. Copies of annual practising certificates are current for all health professionals linked with the rest home in any capacity. Residents with an Occupation Right Agreement have access to the same staff as the remaining residents.  The staff orientation process includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Copies of staff records reviewed show documentation of completed orientation checklists and competencies and a conversation/review with the facility manager after approximately six weeks.  Continuing education is planned on an annual basis, including mandatory training requirements, with some topics covered two yearly. An increasing number of topics are covered through on-line training, which supplement training presentations at the staff meetings. One-on-one training is provided to staff who are not confident undertaking on-line training. Health care assistants have either recently commenced or have completed level three or level four of a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. A registered nurse and an enrolled nurse are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals for all staff. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a clearly 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). A rostering framework sits alongside the documented process, although changes have been made to this when acuity has increased. There was extensive discussion between management and the authorities during the audit to ensure adequate registered nurse cover could be provided for a person currently requiring palliative care within this rest home setting.  Afterhours arrangements are in place with the manager being on call 24/7 to address management type enquiries. The facility coordinator provides some relief and the clinical manager is scheduled for one week on and one week off as first responder on-call. Clinical enquiries may also be managed through the Amberley Medical Centre, which provides 24 hour nursing and medical support and this avenue is used in the absence of the clinical manager, as are other local registered nurses when required. Health care assistants reported they had expressed concerns about the need for an extra staff person over three hours of evening shifts and the desire to have a registered nurse for part of the weekend. According to the manager and rosters sighted, both of these concerns were being addressed. Staff also confirmed there was otherwise adequate staff available to complete the work allocated to them, and there is always someone to call on if additional advice or assistance is required. Residents and family 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. There are two permanent casuals, one of which is a level four health care assistant. A staff member with a current first aid certificate is identifiable for each shift on the roster, as is the medicine administration person.  All residents with an Occupation Right Agreement who are receiving rest home level services have the same access to all staff and these numbers are taken into account when rosters are developed as they are in the same corridors as other rest home level care residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. 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. The organisation seeks updated information from the NASC and GP for residents accessing respite care.  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 and assessments in accordance with contractual requirements. Service charges comply with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB’s ‘yellow envelope’ system (or similar system as indicated in their electronic polices) to facilitate transfer of residents to and from acute care services. 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. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute hospital was sighted. Family of the resident reported being kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  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. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  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 stock checks and accurate entries. Six monthly drug stock checks had occurred in a separate book with the last entry in October 2020. The registered nurse and facility manager stated this task would be carried out by the clinical pharmacist in the future.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range and had been recorded daily.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review was consistently recorded on the medicine chart. Standing orders are not used as the GP service provides a 24 hour on-call service.  There were no residents who self-administer medications at the time of audit. The registered nurse stated it was not considered safe in this environment.  There is an implemented process for comprehensive analysis of any medication errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by qualified cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian on 9 May 2019 which is within the last two years. Recommendations made at that time have been implemented. The facility manager stated preparation had commenced for the season change menu to be submitted to the qualified dietitian prior to May 2021.  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 Christchurch City Council on 22 December 2020. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  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. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals was verified by resident and family interviews and in 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. Resident were seen to be offered choice of meals during the audit process. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. 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. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident’s placement can be terminated. However there was one resident receiving hospital level care at the time of the audit with approval of the ministry of health via the NOHRRA system. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools, such as a falls risk, skin integrity, nutritional screening and pressure injury tool, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the registered nurse trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | 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.  Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | 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 resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard, especially for the resident requiring hospital level of care. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is developed by a fully trained diversional therapist and assisted by an activities coordinator. The activities coordinator has commenced diversional therapist training. It was observed during the audit that the activities team was supported by the health care assistants.  A social assessment and history are undertaken on admission 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. The resident’s activity needs are evaluated clearly and as part of the formal six monthly activity care plan review.  Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through interviewing the residents. Residents interviewed confirmed they find the programme varied and interesting. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal evaluations have occurred for residents’ with significant change of needs. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of electronically recorded short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for all types of infections and for wounds. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. Formal long term care plan evaluations have not occurred every six months in conjunction with the six-monthly interRAI reassessment; this requires corrective action. |
| 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 | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a ‘house doctor’, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in the reviewed residents’ files, including one to the palliative nurse specialist and one for physiotherapy. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate and calling the house GP after hours as confirmed by the GP during interview. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. This includes placing rubbish in the designated bins according to general, sharps or recycling, for example. A regional company is contracted to remove the waste and the sharps container is collected when needed.  An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Chemicals and cleaning products are stored safely and material safety data sheets were available in these areas. Appropriate signage is displayed where necessary and a hazardous substances register that is being regularly updated was sighted. Staff interviewed knew what to do should any chemical spill/event occur.  There is provision and availability of protective clothing and equipment and staff were observed using these. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness with an expiry date of 22 October 2021 is publicly displayed near the front entrance.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. Hot water temperatures are monitored monthly and any deviation from the safe limits is acted upon with recorded examples sighted.  There is an external courtyard and pathways for residents to sit in or walk around. These external areas are safely maintained and are appropriate to the resident groups and setting.  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. A maintenance recording book confirmed reports that required repairs and maintenance tasks are completed in a timely manner. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All twelve studio units have their own ensuite with a toilet, shower and hand basin. The nine other rest home rooms have a hand basin only in them. There is one shower and three toilets available for the residents in these rooms. Residents interviewed are satisfied with the arrangements, although one is keen to have their own ensuite and already has their name down for the next available studio unit. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Twelve of the rooms are in studio units, each of which is occupied under an Occupation Right Agreement. Three of these can accommodate two residents if required; however, at the time of audit none of these were shared. Rooms are personalised with furnishings, photos and other personal items displayed. Staff and residents reported the adequacy of bedrooms.  There is sufficient room to store mobility aids, such as walking frames, and mobility scooters can be parked in the garage. Spare fold up wheelchairs are in hallway recesses. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. A dining room is of sufficient size and a multi-purpose lounge area enables easy access for residents and staff to move around in. Additional seating areas for relaxation or privacy are near the front entrance and in a sunroom at the end of one of the wings. The studio units each has its own dining/lounge area. Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The laundering of residents’ personal items and of the household linen is undertaken on site in a small dedicated laundry. All staff share responsible for the laundry tasks and health care assistants interviewed reported a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Previously reported laundry complaints are no longer evident.  There is a dedicated cleaner who reported during interview that appropriate training has been completed, which was confirmed in training records sighted. This person was aware of ensuring safe handling of the cleaning trolley, of the storage and handling of chemicals and of residents’ rights. Documented cleaning schedules that include spring cleaning are available. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. A relief person is available part-time in weekends and as needed.  Cleaning and laundry processes are monitored through the internal audit system and records of these for October 2020 were viewed. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are available and applicable flip chart are displayed and known to staff. A fire safety compliance company undertakes regular checks. 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.  The current fire evacuation plan was approved by the New Zealand Fire Service on 19 January 2017 and permits a mock evacuation only, without an alarm, to be undertaken every six months. A recent discussion with staff and residents that included a mock trial evacuation was undertaken 15 March 2021. Copies of evacuation processes are on the back of all bedroom doors. Fire and security training is a component of the new staff orientation programme and ongoing training for all staff is provided annually. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas BBQ were sighted and meet the requirements for full occupancy. In addition to bottled water, there is a water storage tank located in the attic of the facility. Regular checks of these supplies are undertaken as per the internal audit regime. Emergency lighting is tested when the fire systems are checked.  Call bells with ceiling mounted digital read outs alert staff to residents requiring assistance. Records confirmed a call system audit is completed six monthly and residents interviewed are satisfied with staff response timeframes.  Appropriate security arrangements are in place including outside sensor lights, window latches in place, doors locked before nightfall, staff security check sweeps at night. A security company monitors the facility alarm system and a local Amberley drive around security service passes regularly. The safety and security needs of all residents are being met in the same way. The studio units sit under the same roof and share the hallway with the rest home rooms. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas have natural light, opening external windows and/or patio doors to the outside. Fans are used when additional ventilation is required. Heating is provided by four heat pumps in communal areas. There is batten heating in the ceilings of all rooms, including residents’ bedrooms, which are thermostatically controlled, although can be individually altered according to personal preferences. Underfloor heating is in the hallways and studio units and a fan heater is in the main communal bathroom. Temperatures are monitored and evidence of this was available. Areas were well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. There are not currently any residents who smoke. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service implements 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 Canterbury Health Laboratories. The infection control programme and manual are reviewed annually.  The clinical manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager and tabled at the quality/risk committee staff meeting. This committee includes the facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, 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. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IPC coordinator has appropriate skills and knowledge for the role and has been in the role for three months. They previously worked in an infection control unit and as trainer in the correct use of personal protective equipment at Nelson Marlborough Institute of Technology. Training through Healthlearn has been started but was yet to be completed. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP, local practise nurses and the IPC coordinator nurse at another facility, as required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. These were sighted during the audit. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed on 20 July 2019 and included appropriate referencing.  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 are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by a suitably qualified RN who is the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when a respiratory illness outbreak occurred in January 2021.  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 fluids during hot weather and not visiting residents in their rooms when they are sick. For this a new system has been implemented putting a red square on the doors of sick residents to indicate other residents are not to enter or visit. This was developed following the recent outbreak and has worked well following a discussion with the residents at a residents’ meeting. Minutes for this was sighted. Family members of a sick resident commented how this red square was effective. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | 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 IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  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. This is reported by the clinical manager, IPC committee and facility manager. Data is benchmarked externally via the electronic system in use with other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.  A summary report for a recent respiratory infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | 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, should this be required. The clinical manager is the restraint coordinator and has undertaken relevant training. Staff are educated on de-escalation techniques and kept updated on the safe use of enablers and restraint. There are not currently any restraints or enablers in use at this facility and the facility manager and staff were unable to recall any use of such devices. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | On review of five residents’ long-term care plans it was identified there were no specific nursing evaluations to indicate the response to the documented interventions or progress gained towards the desired outcome.  There was clear evidence of ongoing evaluations in the progress notes and for the short-term care plans indicating the responses of the resident towards or away from the goal. Included in the short-term care plan evaluations are alterations as indicated to the interventions. | There were no specific nursing evaluations on residents’ long term care plans to indicate responses to the documented interventions or progress gained towards the desired outcome. | Residents’ service delivery plans are evaluated at a minimum of six monthly and in a comprehensive way. Evaluations are documented, resident-focused, indicate the degree of achievement or response to the support and/or interventions and progress towards meeting the desired outcome.  180 days |

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

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

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

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

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End of the report.