# Whitehaven Healthcare Limited - Glendale Retirement Home

## 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](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:** Whitehaven Healthcare Limited

**Premises audited:** Glendale Retirement Home

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

**Dates of audit:** Start date: 25 February 2021 End date: 26 February 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:** 32

# 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

Glendale Retirement Home provides care for up to 33 rest home level residents. On the day of the audit there were 32 residents.

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

The manager (non-clinical) has been in the role for six years, and is supported by a quality assurance coordinator, registered nurses and a team of long-standing experienced staff. Residents and relatives interviewed were very complimentary of the service provided.

This surveillance audit evidences the service continues to meet the health and disability standards.

## 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. |

A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## 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. |

The manager is responsible for the day-to-day operations. A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes. Goals are documented for the service with evidence of regular reviews.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. Residents, relatives and staff reported that staffing levels are adequate to meet the needs of the residents.

## 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. |

Registered nurses are responsible for care plan documentation. InterRAI assessments and care plans are completed within required timeframes. Planned activities are appropriate to the resident’s assessed needs and abilities. Residents and families advised satisfaction with the activities programme. The service uses an electronic medication management system. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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 facility building warrant of fitness had expired and was unable to be completed due to Covid-19 restrictions. A certificate 12b has been issued by Dunedin City Council evidencing the facility is safe, and the building warrant of fitness will be completed and issued in December 2021.

A preventative and reactive maintenance schedule is in place. The facility is spacious and has safe access to all communal areas. The outdoor areas are well maintained and is easily accessible to residents using mobility aids.

## 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. |

Glendale has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service currently has no residents requiring restraint or enablers.

## 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. |

Glendale retirement home continues to implement their infection surveillance programme. Infection control issues are discussed at both the infection control and quality/staff meetings. The infection control programme is linked with the quality programme.

Policies, procedures and the pandemic plan has been updated to include Covid-19. Large posters detailing information for residents, visitors, contractors and deliveries have been pre-prepared for each level of lockdown. Resource folders are easily accessible for staff. Training has been provided around Covid-19 preparedness and adequate supplies of personal protective equipment were sighted and easily accessible.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 41 | 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](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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the manager on the complaints register. Two complaints have been received since the last audit: one in 2019 and one on 2020. No complaints have been received in 2021 year to date. Documentation and correspondence reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. The registered nurses, caregivers, and diversional therapist interviewed confirmed that complaints and any required follow-up is discussed at staff meetings as sighted in the minutes. Complaint documentation requiring changes to care planning are signed by staff once read. Residents advised that they are aware of the complaints procedure and how to access forms and felt comfortable discussing concerns with the registered nurses and the manager. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Comprehensive information is provided at entry to residents and family/whānau. Five residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. The manager and registered nurses are available to residents and relatives and they promote an open-door policy. Incident forms reviewed in January and February 2021 evidenced that relatives had been notified on all occasions. The two registered nurses, four caregivers and the diversional therapist interviewed fluently described instances where relatives would be notified. During Covid-19 lockdown levels relatives were updated via emails and phone calls. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Glendale Retirement Home is a privately-owned service that provides rest home level care for up to 33 residents. On the day of audit there were 32 rest home residents including two residents on YPD contracts.  Glendale has an annual business quality and risk management plan. The 2020 business and quality plan has been reviewed. The 2021 plan is being implemented.  The manager (previous owner) is non-clinical and has been in her current role since February 2015. The manager is supported by two experienced registered nurses, the quality assurance coordinator and a team of long-standing experienced staff.  The manager maintains weekly contacts with the owner and completes a three-monthly report to include: quality information; staff training; occupancy data; and other business-related issues.  The manager has completed at least eight hours of professional development including attending age residential care meetings, a management and leadership study day and completing a first aid course. |
| 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 quality assurance coordinator is responsible for implementing a quality and risk management system. Monthly accident/incident reports, infections and results of internal audits are completed. An internal audit programme is in place that includes aspects of clinical care. Issues arising from internal audits are either resolved at the time or developed into a corrective action plan. The closure of corrective actions resulting from the internal audit programme was recorded and signed off by the manager. Monthly health and safety and infection control data is discussed at the monthly meetings, then the reports are taken to the monthly combined staff/quality meetings. Quality/staff and resident meeting minutes include an accurate reflection of the discussion/outcomes of the meetings, including follow-up to actions taken as matters arising. Record of monthly risk identification, and quality indicators is maintained and discussed at the monthly meetings and a copy is filed with the completed monthly internal audit.  A resident survey has been completed annually which evidenced satisfaction increased around food services (up 18%), activities (up 17%) and open disclosure (up 44%) with more respondents answering the question. A corrective action was implemented around the laundry service where satisfaction has decreased by 14%.  The service continues to implement the falls prevention programme. There is monthly data around all incidents and accidents and infections. Data around falls, is collated, and analysed for trends. Areas of the building and times of falls continue to be identified and monitored to identify ‘high risk’ areas. Dining room activities continue, there are posters of exercises displayed on each corridor for residents to complete during the day. In 2018, the annual review of falls data evidenced a total of 174 falls; exercises were introduced three times a week. The caregivers interviewed described how they actively look for potential hazards in resident rooms and throughout the facility. Staff continue to support and promote resident independence and minimise risks of falls. Falls are discussed at all meetings and caregivers have input into fall prevention strategies. Management reported that the annual holidays residents have the opportunity to go on requires a certain level of fitness, which appears to be a good motivator for residents to complete exercises. Annual total falls were 100 for 2019, and 57 in 2020. |
| 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 | Glendale retirement home collects incident and accident data and reports aggregated figures monthly to the quality meeting. Incident forms are completed by staff, the resident is reviewed by the RN at the time of the event and the form is forwarded to the nurse manager for final sign off. Ten incident forms reviewed for January and February 2021 identified registered nurse follow-up, and relatives had been notified. Neurological observations were completed for all unwitnessed falls. Opportunities to minimise future risks (where possible) were identified and implemented.  Minutes of the combined quality/staff meetings reflected a discussion of incident statistics and analysis. The caregivers interviewed could discuss the incident reporting process.  Discussions with the manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. One section 31 notification has been completed following a resident accident (off site). |
| 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 | There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files were reviewed (one registered nurse, and four caregivers employed since the last audit). All had relevant documentation relating to employment, and current appraisals.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.  There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. There is evidence in the registered nurse files of attendance at the DHB external training. Interviews with caregivers confirmed participation in the New Zealand Qualification Authority through the Careerforce training programme. Currently there are 12 caregivers with level 3 NZQA, and one with level 4. Another two caregivers are completing level 4, and one caregiver is completing level 3. A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed, and a record of completion is maintained and signed. Competency questionnaires were sighted. Both registered nurses are interRAI trained. All staff have current first aid certificates. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Glendale retirement home has a documented rationale for determining staffing levels and skill mixes for safe service delivery.  There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager works five days a week, and the quality assurance coordinator works three days a week. They are supported by two registered nurses who work 7 am to 4.30 pm across seven days. Another nurse provides on-call cover, shared with the registered nurses.  They are supported by three caregivers in the morning: 2x 7 am to 3.15 pm and 1x 7 am to 1 pm.  Two caregivers work in the afternoon shift from 3 pm to 11 pm. There are two caregivers that work on nightshifts.  Interviews with the registered nurses, caregivers and residents confirmed that there are sufficient staff to meet care needs. |
| 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 | Glendale retirement home have implemented an electronic medication management system. The supplying pharmacy couriers all medicines in blister packs for regular and ‘as required’ medications. Medications were checked and signed on arrival from the pharmacy.  Registered nurses and caregivers are assessed as medication competent to administer medication. Standing orders were not in use. The medication fridge temperatures and room temperatures have been monitored daily and were within the acceptable range. Ten medication files were reviewed. Medication reviews were completed by the GP three monthly. PRN medications were prescribed correctly with indications for use. Medications are stored securely in the locked nurses’ station. Eye drops, and creams were dated on opening. There were no expired drugs on site. There were no self-medicating residents. |
| 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 | There is a functional centrally located kitchen and all food is cooked on site. There is a food services manual in place to guide staff. There are two cooks who have food handling certificates and considerable cooking experience. Food is served from the main kitchen to the dining area adjacent to it. A current food control plan is in place expiring on 30 November 2021. The Dunedin City Council awarded Glendale an ‘A’ grade status from July 2020 to January 2022.  Special diets are being catered for. The five-week seasonal menu has been reviewed by a registered dietitian. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. The cook interviewed was aware of changes in resident’s nutritional needs and was knowledgeable around the current nutritional requirements of residents.  Kitchen fridge/freezer temperatures and food temperatures were recorded and are signed off by the manager weekly. All food is stored appropriately. There is special equipment available for residents if required. Residents interviewed reported satisfaction with meals. Meals are discussed at the resident meetings and feedback is given to the kitchen. The satisfaction survey evidenced 82% satisfaction around food services. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. The registered nurses and caregivers follow the plan and report progress against the plan each shift. There is documented evidence on the family contact form in each resident file that indicates relatives were notified of any changes to their relative’s health. Short term care plans are used for short term/acute changes in care. These were in place for wounds and infections in the resident files reviewed.  There were seven wounds on the day of the audit including skin tears, surgical wounds, chronic ulcers, one stage 1 pressure injury (non-facility acquired) and one stage 2 pressure injury on a toe. All wounds had individual wound assessments, plans and evaluations which indicated progression or deterioration of the wounds. Adequate dressing supplies were sighted in the treatment room. The registered nurses described referrals to the wound care specialists when required.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern.  Monitoring forms are used for weight and vital signs, blood sugar levels, pain, challenging behaviour, food and fluid charts. |
| 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 | A qualified, experienced and enthusiastic diversional therapist (DT) typically works a minimum of 32 hours per week Monday to Friday. Hours are flexible to enable attendance at special events at weekends and evenings and individual needs according to resident interests. A resident activity interest form is completed on admission. Each resident has an individual activity plan which is reviewed six-monthly. The service receives feedback on activities through one-on-one feedback, surveys of individual activities, outings and entertainment, resident’s meetings and annual resident and relative surveys. One resident has been nominated to attend part of the staff/quality meeting to provide feedback from residents.  Volunteers and caregivers assist with individual and group activities during the week and on weekends. Two long-serving volunteers are available as required and provide focused support to specific residents. The activity programme is varied and meets the recreational needs of the resident group. The diversional therapist attends on-site in-service and is in regular contact with other diversional therapy group meetings.  Activities are meaningful and include (but are not limited to), twice weekly van outings, exercises, entertainment, group games, happy hour. There are monthly church services, the chaplain ‘pops in’ to visit residents and the priest offers weekly communion for residents. On the day of audit, residents were observed participating in a variety of activities. One-on-one activities are provided for residents who are unable or choose not to be involved in group activities.  All residents are supported to maintain their community links and are also involved in meaningful activities of their choosing. On admission to the service residents are asked “what would you like to do?” Comments on resident surveys have included “I thought my time of going on holidays and going on walks were over”. Residents interviewed were very complimentary of the activities provided. One resident stated they “enjoy the freedom of going on holiday, going out with family and continuing to do what I have always done”. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six-monthly. Written evaluations identified progress towards goals. The GP reviews the residents at least three monthly or earlier if required. Short-term care plans reviewed had been evaluated at regular intervals, and either resolved or interventions were added to the long-term care plan. Ongoing nursing evaluations occur as indicated and are documented on care plans and within the progress notes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building warrant of fitness has expired. A new building warrant of fitness could not be awarded as compulsory checks could not be completed during the Covid-19 lockdown levels. The service has been awarded a certificate 12b by the Dunedin City Council. This assures the facility systems are safe and extends the warrant of fitness for 12 months. Preventative and reactive maintenance occurs. Monthly hot water temperatures are maintained and remain within acceptable levels. Corrective actions have been completed when temperatures are not within ranges.  There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the well maintained and landscaped outdoor areas. Seating and shade are provided. The facility has a designated resident smoking area for residents.  The caregivers interviewed stated they have sufficient equipment including mobility aids, wheelchairs and pressure injury resources to safely deliver the cares as outlined in the residents’ care plans. |
| 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 | Glendale retirement home continue to implement their infection surveillance programme. Individual infection forms were completed for all infections. Infections were included on a monthly register and a monthly report and graphs were completed by the infection control coordinator (registered nurse). Infection control issues are discussed at the infection control meeting and combined quality and staff meetings. The infection control programme is linked with the quality programme. In-service education is provided annually and in toolbox talks when required. There have been no outbreaks since the previous audit.  Covid-19 was well prepared for, the one recommendation around resident temperature checks was accommodated. A resource folder was maintained, policies, procedures (including staff management) and the pandemic plan have been updated to include Covid-19. The quality assurance coordinator has developed posters for each level of lockdown, with clear instructions for staff, visitors, contractors and deliveries to the service. These are displayed at the main entrance; this information is emailed to relatives, so everyone is following the same advice. Extra training was provided around Covid-19, including isolation procedures, personal protective equipment usage, and hand hygiene. Procedures were developed and followed by staff around arriving and leaving work. Red and green areas were identified. A Covid-19 wheelie bin, and a grab and go kit are in place. Adequate supplies of personal protective equipment were sighted. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint minimisation and safe practice policy that is applicable to the service.  The registered nurse is the restraint coordinator. Glendale retirement home is restraint free, and there were no residents using enablers on the days of the audit.  There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0.  Restraint/enabler and challenging behaviour training has been provided annually. Caregivers interviewed could fluently describe the differences between restraint and enablers and procedures around these. |

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

|  |
| --- |
| No data to display |

End of the report.