

# Ambridge Rose Cottage Limited

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## 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 Q-Audit Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Ambridge Rose Cottage Limited

**Premises audited:** Ambridge Rose Cottage Limited

**Services audited:** Dementia care

**Dates of audit:** Start date: 6 August 2021 End date: 6 August 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:** 23

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Ambridge Rose Cottage provides dementia level of care for up to 24 residents. There were 23 residents on the day of the audit. The service is one of three facilities owned by Ambridge Rose. The facility manager (FM) is supported by the owner/chief executive officer (CEO) other co-owner/manager, the chief operating officer (COO), and the nurse manager (NM) from the other sister facility. Residents and families expressed satisfaction with the care provided. There have been no significant changes to the management since the previous audit.

This surveillance audit was conducted against a sub-set of the Health and Disability Services Standards and the service's contract with the district health board. The audit process included a review of policies and procedures, review of residents' and staff records, observations, and interviews with management, staff, and a general practitioner.

There was one area requiring improvement relating to the medication management system.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents, and families is promoted and was confirmed to be effective. There are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents. The residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The complaints process is accessible and meets consumer rights legislation.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The business strategic and quality risk management plan includes the scope, direction, goals, values, and mission statement of the organisation. There is one governance body and CEO for the three facilities they own. Organisational performance is monitored regularly and effectively. The facility is managed by an experienced and qualified facility manager who has aged care experience.

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

The appointment, orientation, and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance reviews. Staffing levels and skill mix meet the changing needs of 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.		Some standards applicable to this service partially attained and of low risk.
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Care plans and assessments sampled are completed by Registered Nurse within the required time frames, the residents' needs and care requirements are evaluated as required. The required personal care and clinical interventions are implemented. Resident centred care plans are reviewed every six months and short-term care plans are consistently developed when acute conditions are identified. Planned activities are appropriate for the residents' assessed needs and abilities. Residents and family interviewed expressed satisfaction with the activities provided by the activity's coordinators. 24-hour dementia diversion care plan was sighted in all sample care plans. Medication is managed via an electronic platform. Medications are administered by the care team with current medication competencies. Medication charts are reviewed by the general practitioner (GP) three monthly and as required. An improvement is required to ensure "No known Allergies" (NKDA) is completed for residents with no allergies.

Meal services are prepared on-site and served in dining rooms. Residents' food preferences and dietary requirements are identified at admission. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. There are nutritious snacks available 24 hours a day.

## 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.
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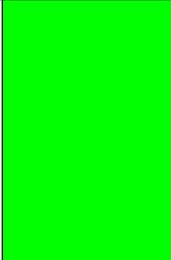
The service has a current building warrant of fitness. Trial evacuations are conducted every six months.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation processes are in place and the facility manager is the restraint coordinator. There were no residents using restraint nor enablers at the time of the audit. The restraint policy outlines that the use of enablers shall be voluntary to promote residents' independence and safety

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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There is a documented surveillance programme that is appropriate to the size and scope of the service. All infections are recorded, with data collated each month, and then annually. Analysis and comparisons are made.

## 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)
<b>Standards</b>	0	16	0	1	0	0	0
<b>Criteria</b>	0	39	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Policies and procedures relating to complaints management are compliant with Right 10 of the Code. Systems are in place that ensure residents and their family are advised on entry to the facility of the complaint process and the Code. The complaints forms are displayed and accessible within the facility. Staff interviewed confirmed their awareness of the complaints process. Residents and families demonstrated an understanding and awareness of these processes.</p> <p>The FM is responsible for complaints management. The review of the 2020 and 2021 registers noted that they were no complaints reported. There were six compliments from family members regarding the service. The FM reported that each complaint will be investigated, and letters of acknowledgment sent as per the Code timeframes. Recommendations and an action plan implemented when required and followed up in a timely manner. There have been no known complaints to external agencies.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Residents and family/whanau members stated they were kept well informed about any changes to their own or 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' family communication records. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>accessed via DHB when required. Communication cards are at times used when required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plan includes the scope, direction, goals, values, and mission statement of the organisation. There is one governance body and CEO for the three facilities under the umbrella of Ambridge Rose. The organisation is owned by two owners/directors, one has the role of the chief operating officer (CEO) and the other is the manager. The board meets every two months and other issues are regularly discussed as they occur. The strategic plan was reviewed in November 2020. The CEO reported that the service was certified for 24 beds.</p> <p>The strategic and business plans are current. The documents describe annual and long-term objectives and the associated operational plans. The FM, COO, and owner/manager report to the CEO. Weekly updates showed adequate information to monitor performance is reported including potential risks, contracts, human resources and staffing, growth and development, maintenance, quality management, and financial performance.</p> <p>The FM is supported by the management team which consists of the owner/CEO, owner/manager, COO, and the NM from another sister facility. Staff and management team meetings are conducted every two months. All members of the management team are suitably qualified and maintain professional qualifications in management, finance, and clinical skills. The FM has over 15 years of experience in the management of residential care facilities. Responsibilities and accountabilities are defined in a job description and individual employment agreement.</p> <p>The service holds contracts with the district health board (DHB), ministry of health (MOH) long-term support chronic health (LTS-CH), day care, and respite services. There were 23 residents assessed as requiring dementia level of care and two attending day care services on the day of the audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	<p>FA</p>	<p>Ambridge Rose Cottage has a quality and risk management framework that is documented to guide practice. This includes management of incidents and complaints, internal and external audit programme, regular family satisfaction surveys, monitoring of outcomes, clinical incidents, and accidents including infections surveillance.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the board, management team, and staff meetings. The FM reports weekly to the Owner/CEO and the board every two months during their sitting. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Family satisfaction surveys are completed monthly and evidence of this was sighted. There have been several improvements to the building structure and environment since the last audit. The improvements include new external rails for residents' support, safety film glass on doors, vegetable garden, thermo-stat controlled heating system, access control with swipe cards to the medication room, laundry and staff room, CCTV, artificial</p>

improvement principles.		<p>grass around the facility, and outside sitting areas.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI long Term Care Facility (LTCF) assessment tool process. Policies are based on best practices and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. These are managed by an external consultant who keeps the service updated on any recent changes. In the interview conducted, staff confirmed that they have access to policies and procedures if required.</p> <p>The FM, Owner/CEO, and the COO described the process for the identification, monitoring, review, and reporting of risks and development of mitigation strategies. The FM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near-miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up in a timely manner. Neurological observations are completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed, and reported to the management. There is an open disclosure policy in place. Any communication with family and general practitioner (GP) following adverse events and if there is any change in the resident's condition, is recorded in residents' records. Family/whānau and the GP interviewed confirmed they are notified in a timely manner.</p> <p>The NM described essential notification reporting requirements, including pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks, and missing persons. They advised there have been no notifications of significant events made to the MOH since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>Human resources management policies and processes are based on good employment practices and relevant legislation. The recruitment process includes reference 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. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them adequately for their role.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>requirements of the provider's agreement with the DHB. Staff training is being provided. Health care assistants (HCA's) have completed Career Force levels four, three, and one. Staff reported that they were currently receiving ongoing training to meet the needs of residents requiring dementia level of care. Staff performance is monitored, and current annual performance appraisals were sighted in all files reviewed. The NM from the other sister facility is currently covering and completing interRAI assessments. The owner/CEO reported that the position of a registered nurse is currently under recruitment.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented and implemented process for determining staffing levels and skill mixes to provide safe delivery, 24 hours a day, seven days a week. The service adjusts staffing levels to meet the changing needs of residents. An after-hours on-call roster is in place, with staff reporting that good access to advice is available when required. Care staff reported there was adequate staff available to complete the work allocated to them. Observations and review of a four-week paid roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All shifts have a staff member on duty with a current first aid certificate and the FM cover during the day, on-call after hours. There are always at least two staff members on duty 24 hours a day. The service has adequate staff to cover any increased needs.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The service uses an electronic medication chart. GP conducts three monthly reviews of medication, sighted in all sampled medication charts, known allergies are indicated. All medication packs are checked by the RN on delivery against medication charts every month. Medicines held in stock are checked every month and any expired medicines are returned to the pharmacy promptly. A registered nurse was observed administering medicines and complying with required medication protocol guidelines and legislative requirements. There were no residents who self-administer medication on audit day. A self-administration process is in place if required. Monitoring of medication fridge temperatures and medication storage room is conducted, and records were sighted. Medications are stored securely in the medication trolley. The service does not store any vaccines onsite. Annual medication competency is completed for all staff administering medications. There are no medication errors reported, the process is in place if there is a medication error. The controlled drug register is current and correct. Weekly and six-monthly stock takes were conducted as confirmed on previous entries. On the day of the audit, there were no residents prescribed controlled medication, and there was no controlled drug stored in the controlled drug cabinet.</p> <p>An improvement is required to complete "No known Allergies" (NKDA) for residents with no allergies identified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food,</p>	<p>FA</p>	<p>The meal services are prepared on-site and served in the allocated dining room. The service employs two cooks. The Group Chef oversees the food management process in coordination with the site Cooks. The kitchen has been</p>

<p>And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>registered with the local council under the food control plan, the certificate is valid. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer menu in place. The residents have a dietary assessment completed on admission which identifies nutritional requirements, likes, and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness of dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly, and supplements are provided to residents with identified weight loss issues. Copies of nutritional requirements forms were sighted. Residents' weight monitoring is completed monthly, and interventions are put in place to address any weight issues with the involvement of the cook and a dietitian</p> <p>The kitchen was observed to be clean and tidy on the day of the audit. A cleaning schedule is in place and implemented. No expired food was found in the kitchen or storage area. Cooked food in the fridge was covered and labelled. Staff were observed to prepare and serve meals in a manner that complies with food safety hygiene and nutritional requirements. The policy requires staff to check food, fridges and freezers temperatures daily and document weekly by making an entry in an automated system. These were completed in records sighted. The residents and family interviewed acknowledged satisfaction with the food service. Snacks and drinks are available for residents who wake up during the night on a 24-hour period.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>In the files reviewed, interventions were adequate and appropriate to meet the assessed needs and desired outcomes. The individual behaviour management plans specified prevention interventions for minimising episodes of challenging behaviours and described how the residents' behaviour was best managed over a 24-hour period. Interviews with residents and families verified that care provided to individual residents was consistent with their needs, goals, and the plan of care. The interviewed GP verified that medical input is sought in a timely manner, medical orders are followed, and care is implemented promptly. Interviewed staff confirmed that care was provided as outlined in the care plans. Appropriate equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are</p>	FA	<p>There is a full range of social activities that are available for all residents to participate in. All residents are assessed and invited to participate in specific activities that are appropriate for their level of ability and interests. The activities can either be individual or group activities conducted by the two activities coordinators with oversight from the FM. Activities offered: including bingo; music sessions; walking groups; van trips, art, craft, and various events celebrations. Activities reflect residents' goals, ordinary patterns of life and include normal community activities, regular events are offered, external entertainers invited, and church groups visit. Attendance lists are completed daily, and documentation is maintained. Individualised activities plan for residents were sighted in sample files. Evaluation of the individual activity plans is completed every six months, or when there is a significant change. A</p>

appropriate to their needs, age, culture, and the setting of the service.		dementia clock is developed for all residents living with dementia outlining planned activities on a 24-hour period. The residents were observed participating in a variety of activities on the audit days. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care plans and activity plans are evaluated every six months and are updated when there is any significant change. Reviews are documented and include the resident's status, any changes, and achievements towards desired outcomes and goals. The InterRAI assessments are conducted six-monthly and the outcomes are used as part of the evaluation process. Multi-disciplinary reviews (which include family input) are conducted to evaluate the effectiveness of the residents' progress. Family and staff input is sought in all aspects of care. Short-term care plans are developed and reviewed as needed.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There have been no changes to the facility since the last audit. The current building warrant of fitness was sighted, and it expires on 4 March 2022.
Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations.	FA	Trial evacuations are completed every six months and the last fire drill was conducted on 25 February 2021. Records of staff attendance are maintained.
Standard 3.5: Surveillance	FA	The surveillance programme is defined and appropriate to the size and scope of the service. All infections are recorded in the residents' files using the nosocomial infection data collection form. Infection data is collected,

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and management meetings. Evidence of completed infection control audits were sighted.</p> <p>Staff interviewed confirmed that they are informed of infection rates as they occur. The GP is informed within the required time frames when a resident has an infection and appropriate antibiotics are prescribed for all diagnosed infections. There has been no outbreak since the last audit. A pandemic plan is in place and adequate personal protective equipment was sighted. Staff, residents, and families are updated on regular Covid-19 latest information.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>commits to provide quality services for residents in a safe environment and work to minimise the use of restraint as per the facility restraint policies ad procedure. The FM /Enrolled Nurse is the restraint coordinator who provides support and oversight for enabler and restraint management in the facility. Restraint is part of orientation and training is provided annually or as necessary. Approved restraint includes bed rails and environmental restraint in the form of locked gates. The staff interviewed were clear regarding the difference between restraint and enabler use. On the audit day, there were no residents using restraint, and no</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	GP conducts three monthly reviews of medication sighted in all sampled medication charts; allergies are indicated, however in four of sampled medication charts, “No known Allergy” (NKDA) is not completed for residents with no allergies.	“No known Allergies” (NKDA) not completed for residents with no known allergies.	<p>Provide evidence that “No known Allergies” (NKDA) completed for all residents with no known allergies in all medication charts.</p> <p>90 days</p>

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

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

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

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

No data to display
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End of the report.