J & R Manuel Limited - Phoenix House Resthome and Hospital

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 Health and Disability Auditing New Zealand 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:	J & R Manuel Limited
Premises audited:	Phoenix House Resthome and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 February 2019 End date: 28 February 2019

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 27

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Phoenix House Rest Home and Hospital is privately owned and operated and cares for up to 30 residents requiring hospital and rest home level care. On the day of the audit, there were 27 residents.

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

The service is managed by a facility manager (FM) who is a registered nurse and has been in the role for over two years. The FM is supported by the owner director and a financial manager. Staff turnover is reported as low.

This audit has identified improvements are required in relation to staff education, implementation of care, self-medicating and medication documentation.

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 family 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.		Some standards applicable to this service partially attained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. The manager is responsible for the day-to-day operations of the care facility. Quality and risk management processes are implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. The health and safety programme meets current legislative requirements. Adverse, unplanned and untoward events are documented and investigated.

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. Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

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 medium or high risk and/or unattained and of low risk.

Care plans are developed by registered nurses. Care plans reviewed were developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners (GP) and visiting allied health professionals.

There is a medication management system in place. Each resident is reviewed at least three-monthly by their general practitioner. Registered nurses and medication competent care staff are responsible for the administration of medicines and complete education and medication competencies.

A range of individual and group activities is available and coordinated by the recreational therapists. The programme reflects the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service.

Safe and appropriate environment

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

The service has a current building warrant of fitness and reactive and preventative maintenance occurs.

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.

There are policies and procedures on safe restraint use and enablers. A registered nurse is responsible for the restraint coordinator role. There was one resident voluntarily using an enabler and two residents with restraints. Staff receive training around restraint and behaviours that challenge.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	13	0	2	1	0	0
Criteria	0	37	0	3	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the hospital front entrance. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There have been no complaints documented since previous audit. Systems and processes are in place to ensure that any complaint received is managed and resolved appropriately. Residents and the family member interviewed advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The five residents (four rest home and one hospital) interviewed, reported that staff communicated with them appropriately. There is a policy to guide staff in their responsibility around open disclosure. Staff report incidents and accidents to management. Staff are required to record family notification when recording an incident or accident. Incidents reviewed met this requirement. The family member (rest home level care) interviewed, confirmed they are notified following a change of health status of their family member. There was an interpreter policy and contact details of interpreters were available.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Phoenix House is a family owned and operated facility that was established in 1987. The facility manager receives support from the financial manager who is one of the owner/director's and the other director. Both the owner/director and the financial manager are registered nurses with current annual practicing certificates. The facility manager is a registered nurse (RN) with 30 years of nursing experience in the community and hospital setting and has been in a leadership role at this facility since November 2016. The facility provides care for up to 29 residents at rest home and hospital level of care. One room previously included in the total numbers has been decommissioned. There were 27 residents on the day of audit. There were 18 rest home residents and nine hospital level residents including one resident admitted under a primary care contract and one resident admitted under a respite care agreement. All other residents were under the ARRC agreement. An annual business plan has been developed that includes a philosophy, values and measurable goals. Business goals have been documented for 2019 and are being implemented. The facility manager has completed at least eight hours of training related to management of an aged care facility, relevant to her role and responsibilities.
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 service has a quality assurance and risk management programme in place. Policy and procedures are reviewed annually by the owner director in consultation with the facility manager. The service has a range of policies, associated procedures and forms. Staff interviewed had a good understanding of the quality and risk management systems in place at Phoenix House. Quality and risk management issues are discussed at the bi monthly quality and health and safety meetings and quarterly staff meetings. Meeting minutes reviewed included discussion about adverse events and staff training. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies. Quality improvement data is collected, collated and analysed. Quality data is regularly communicated to staff via staff meetings, and a copy of the previous meeting minutes are available for staff to read. Internal audits are completed, and corrective actions are implemented for areas of non-compliance. There was evidence in the staff meetings to verify staff are informed of audit results and corrective actions. The facility manager reports adverse events to the owner director. There is a current hazard register in place, which is regularly reviewed.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or	FA	Adverse events are documented and reported to the RN on duty and/or FM. These events are recorded on a hard copy adverse event form (ie, accident/incident forms). The form is completed, received by the FM and collated by administration staff. Documents reviewed identified that when the RN determines it is not necessary to contact the family, that this is clearly recorded on the incident form. The adverse events form

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.		records if the family have been contacted and the date and time of the contact. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events. Clinical evaluation of residents following an adverse event is conducted by a registered nurse and was evidenced in eight accident/incident forms selected for review. The facility manager is aware of the requirement to notify relevant authorities in relation to essential notifications. Norovirus was reported to Public Health in 2017.
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.	PA Low	There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (two caregivers, one RN, one cook and one recreational therapist) included evidence of the recruitment process, signed employment contracts, police vetting and completed orientation programmes and annual performance appraisals. Copies of practising certificates are kept on file. Staff turnover was reported as low. The service has an orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Staff advised management was in the process of engaging Careerforce assessors to enable staff to complete national caregiving qualifications. One of the current six RNs, is interRAI trained with more scheduled for training this year. An in-service education programme is being implemented. Regular in-services are provided by a range of in-house and external speakers, however not all compulsory education has been provided.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Phoenix House has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. Families/whānau and residents interviewed stated that they felt there was sufficient staffing. There is a registered nurse rostered on each shift for 27 residents (18 rest home, nine hospital residents). The manager (RN) works full-time. In the hospital for nine residents, there is an RN on duty on the morning and an RN on afternoon shifts and night shift. The RNs are supported by two caregivers (one full and one short shift) on duty in the morning shift, one caregiver (finishing at 9.15 am or longer if the RN deems it necessary). The RN is on her own at night but with caregiver assistance available. In the rest home and Rimu wing (13 rest home level care residents), there are two caregivers (one long and one short) on morning shift. One caregiver is on duty on afternoon and night duty. In the Rimu for five rest home residents, there is one caregiver on a short morning shift. This area is covered

		by staff from the other wings for afternoon and night shifts. The facility manager provides on call cover after hours. Extra staff can be called on for increased resident requirements. Activities staff are rostered on five days a week. A morning caregiver completes the laundry, and reported there is adequate time allocated for this.
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.	PA Moderate	There are policies and procedures in place for all aspects of medication management, including self-administration. One resident who was self-administering their own medicines did not comply with the organisations requirements for residents who are self-medicating. Standing orders are not in use. The facility uses a medico pack system. The medication management policies and procedures comply with medication guidelines. Medicines are stored securely in accordance with relevant guidelines and legislation. Medication administration practices comply with the medication management policy on the medication rounds observed. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The CD register did not evidence weekly checks. Registered nurses and senior medication competent care staff administer medications in the hospital and rest home. Staff attend annual education. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked weekly. Staff sign for the administration of medications on a medication signing sheet. Ten medication charts were reviewed (six hospital and four rest home). Not all charts identified whether there were allergies or not. Medications are reviewed at least three-monthly by the GP. There was photo ID. 'As required' medications had indications for use charted.
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	All food is prepared and cooked on-site at Phoenix house. Fridge and freezer temperatures are checked daily and recorded weekly. Food temperatures are documented daily. Foods were date labelled and stored correctly. A cleaning schedule is maintained. There is a registered food control plan in place with a verification expiry in June 2020. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. The head cook oversees the procurement of the food and management of the kitchen. There is a four-weekly rotational menu which has been approved by a dietitian. The meals are prepared in a well-appointed kitchen and served directly from a bain marie to the residents in the dining room which is located opposite the kitchen. The cook receives notification of any resident dietary changes and requirements. Dislikes and food allergies are known and accommodated. Supplements are provided to residents with identified weight loss. Weights are monitored monthly or more often if required. Resident meetings and surveys provide an opportunity for resident feedback on the food service. Residents and families interviewed stated they were satisfied with the

		food service.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	When a resident's health changes, the RN initiates a medical visit by the GP or nurse specialist review such as referral to physiotherapist or wound nurse. Short-term care plans are developed to meet the short-term needs and supports of the residents. Changes to a resident's health is communicated to staff on duty and at handovers to oncoming staff. There is documented evidence of relatives being kept informed on the resident health status form including: (but not limited to) GP visits, infections and medications. Residents stated their needs are being met. Interviews with registered nurses and care staff demonstrated an understanding of the individualised needs of residents. Not all interventions supporting all assessed needs had been documented in the resident's short-term/long-term care plan. Staff have access to sufficient clinical supplies including dressing products. Resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management evaluation plans are in place for current wounds. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. Wounds included skin tears, surgical wounds, skin conditions and one resident with two non-facility acquired pressure injuries (one stage one and one stage two). Monitoring forms are in use as applicable such as weight, vital signs and wounds.
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	Two recreational officers are employed to coordinate and implement the activities programme for all residents. There is a Monday to Friday programme from 9.30 am to 12.30 pm with organised activities in the weekends such as church services movies and walks with the caregivers. Group activities reflect ordinary patterns of life and include planned visits to the community and local areas of interest. The service has access to a wheelchair van and the one of the recreational officers is also is also employed as local ambulance officer. Community visitors include school children and pet owners. Each resident is free to choose whether they wish to participate in the group activities programme. There is allocated one-on-one time for residents who choose not to or are unable to participate in group activities. Residents have a recreational profile over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly and activities staff document recreational progress notes at least weekly for each resident. Participation is monitored. Residents have the opportunity to feedback on the activity programme through resident meetings and surveys.

		Residents and family interviewed were happy with the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Three of the five long-term care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. One resident was on a respite contract and was a new admission and did not require evaluation. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the long-term residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home and one monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan.
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 holds a current warrant of fitness which expires 27 June 2019. There is no maintenance person on-site but the facility manager or registered nurse phones contractors when maintenance is required. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms are carpeted, and communal showers and toilets have non-slip vinyl flooring. All halls have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have some seating and shade. There is safe access to all communal areas.
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	Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified, and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. An outbreak in 2017 was managed appropriately with notifications made as required. Systems are in place that are appropriate to the size and complexity of the facility.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies and procedures on restraint minimisation and safe practice. The policy states that the facility prefers no or minimal restraint. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were two residents using three restraints (two bedrail and one lap belt) and one enabler (bedrail) in use. The residents using an enabler had given consent voluntarily.

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)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	An education plan is documented as part of the quality system. At least eight hours is offered annually, however not all mandatory training has been provided.	Not all required education has been provided as per contractual requirements. Staff have not received training in abuse and neglect, falls minimisation, continence, skin integrity and chemical safety since 2016.	Ensure education planning includes all required education as per contractual requirements and resident current needs. 90 days
Criterion 1.3.12.5 The facilitation of safe self-administration of	PA Low	Policy states residents are assessed for competency to self-medicate, however this had not been completed for one resident.	The resident self-medicating did not have a documented competency in place.	Ensure residents who self-medicate evidence they are competent to do so as

medicines by consumers where appropriate.				per policy. 30 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	Controlled medications are securely stored in a locked cabinet and administered by two staff. Registered nurses complete weekly stocktakes of controlled drugs and document in the controlled drug register, but this was not always completed as required. Medications are stored securely in a designated medication room. The GP is responsible for charting of oxygen and the documentation of allergies on the prescription chart, however these had not been documented as required.	(i). The controlled drug register evidenced monthly or longer intervals between stock checks. (ii) Oxygen in use had not been charted (charted on the day of audit). (iii) Three of ten, education charts reviewed did not have allergies or no allergies known documented	(i). Ensure controlled medication stocktakes occur weekly as per legislation. (ii) Ensure oxygen administration is charted. (iii) Ensure allergies or nil allergies are documented 30 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Pain charts are used as part of the ongoing assessment of residents, however the effectiveness of 'as required' analgesia is not always documented. Each wound in place was assessed and evaluated. Monitoring charts included food and fluid monitoring, weight, blood sugar levels, two hourly turn charts, oxygen saturations and observations for blood pressure, temperature, respiratory and pulse rate. The RN reviews the monitoring charts daily and initiates interventions as required. Not all care interventions had been documented in the resident files.	(i) Interventions had not been documented to manage required interventions for a hospital resident with interRAI triggers of cardio respiratory needs, weight loss, incontinence, mood and activities of daily living, (iii) Effectiveness of 'as required' analgesia is not always documented for a resident on controlled drugs.	(i) Ensure interventions/supports are documented for all assessed need. iii) Ensure the effectiveness of 'as required' pain medication is documented. 90 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.

No data to display

End of the report.