

Warkworth Hospital Limited - Warkworth 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 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:	Warkworth Hospital Limited	
Premises audited:	Warkworth Hospital	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 5 November 2019	End date: 5 November 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:	37	

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

Warkworth Hospital Limited is the governing body and is responsible for the services provided at Warkworth Hospital. The organisation provides rest home and hospital care for up to 37 residents. There have been changes to the organisation and the facility since the last audit. An additional room has been added, consent for a large building addition has been granted, refurbishment continues and there has been a reduction in the number of nursing staff.

This unannounced surveillance audit was been undertaken to establish compliance with a subset of the Health and Disability Services Standards and the provider's contract with the district health board (DHB). The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family, management, staff and the general practitioner (GP).

Improvements are required regarding annual performance appraisals, the medication management system and the infection control surveillance programme.

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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Management and staff communicate in an open manner and residents and family members are kept up to date when changes occur. Systems are in place to ensure residents/family are provided with appropriate information to assist them to make informed decisions. Interpreter services are accessible if required. Resident meetings provide residents with the opportunity to discuss compliments and concerns. The complaints process meets consumer rights legislation. A complaints register is maintained.

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.
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The directors set the strategic direction and monitor organisational performance. Day to day operations are the responsibility of the nurse manager and the operations manager. Both managers are suitably experienced.

There is a documented quality and risk management programme that supports the provision of clinical care. Quality and risk data is recorded and shared with staff and management. Quality data collected covers the key components of service delivery. There is well established internal auditing process. The adverse event reporting system complies with policy and staff document and report adverse, unplanned or untoward events. Improvements are made as required.

All staff are provided with orientation and ongoing training. The staffing skill mix is appropriate for the level of care and services provided.

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.
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Residents are assessed prior to entry to the service to confirm their level of care. The process for assessment, planning, evaluation and exit are provided by suitably qualified staff. InterRAI assessments and individualised care plans are documented and these are based on a comprehensive range of information and accommodate any new problems that might arise. Files sampled demonstrated that the care provided and needs of residents are reviewed and evaluated.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP).

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are 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.
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Changes to the building including the additional resident room and refurbishments have not altered the emergency evacuation plan. The approved evacuation was sighted. There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has policies and procedures that support the minimisation of restraint. There was one resident using an enabler and none on restraint at the time of the audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. The use of enablers is voluntary for the safety of residents in response to individual requests. In-service staff education on restraints, enablers and the management of challenging behaviour is provided.

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.		Some standards applicable to this service partially attained and of low risk.
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The infection prevention and control surveillance programme is described in policies and procedures.

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	14	1	1	1	0	0
Criteria	0	39	1	2	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	The complaints policy meets consumer rights legislation. The complaints process is introduced to residents and their family members during the admission process. Information about the residents' right to complain is displayed. Complaint forms are easily accessible. Residents and family members interviewed confirmed their knowledge of the complaints process and stated they would feel comfortable raising any concerns. Residents are also provided the opportunity to raise any concerns, and provide feedback, during the residents' meetings. Records of the residents' meetings included feedback from residents regarding day to day matters. These meetings are chaired by the activities person and are now conducted every three months. There is evidence in the records that any resident concerns are addressed. Complaints are a standing agenda item for staff meetings. The last formal complaint was in June 2018 and was investigated by the district health board. The complaint was found to be unsubstantiated and had been added to the complaints register.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	Documentation of open disclosure following incidents/accidents was evident on the event reports sampled. Family members interviewed reported they are informed of any accident or incident and this is documented in the family contact event notes. Staff, residents and family members interviewed all confirmed that management have an open-door policy and are responsive to any concerns. The service has not required any access to interpreting services for the residents. Policies and procedures are in place if interpreter services are needed to be accessed.

provide an environment conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>There have been no changes in governance since the last audit. The mission statement and purpose are documented. The current business strategy includes some large additions to the service over the next few years, some of which are now consented and ready to proceed.</p> <p>Day to day operations are delegated to two managers. The nurse manager is a registered nurse (RN) and has been in the role for 14 years. The operations manager has previous health experience and has been in the role for 12 years. One of the directors visits the facility regularly and meets with the managers. Both members of the management team attend the required hours of education and training covering clinical and management topics and have recently attended the aged care association conference.</p> <p>The facility can now provide care for up to 37 residents. One additional room has been added since the last audit. Approval for the additional room from the Ministry of Health was sighted. There are 26 designated hospital level beds, and 11 beds which can be used for residents who require either rest home or hospital level care. On the day of the audit there were 37 residents. This consisted of nine rest home residents, 25 hospital residents, and three residents under the age of 65 years.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There have been no changes to the quality and risk management system since the last audit. Policies and procedures are available to guide staff. There is an archive system in place for obsolete documents. The management team take joint responsibility for updating documents. All documents are controlled and password protected. There is a mechanism for alerting staff to new documents. Policies and procedures are updated in an ongoing manner.</p> <p>Quality and business goals are documented. Achievement towards business goals is monitored by the directors through access to all accounts, payroll and banking systems. A range of quality data is collected. This includes internal audits; resident satisfaction; adverse events; complaints and infection control. Quality data is discussed at staff meetings and during handover between the nurses. Internal audits completed since the last audit have included medication, residents/family satisfaction surveys, meals and activities. These audits were sampled and confirmed satisfaction with the service.</p> <p>Actual and potential risks are identified and documented in the hazard register and in the risk management plan and have not changed since the last audit. The operations manager had a council member site meeting regarding the planned additions to the facility to ensure all council and health and safety requirements are maintained. Hazards are identified and isolated. Risk management processes are reviewed annually by the directors with input from the</p>

		management team.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The nurse manager and the operations manager confirmed their obligations in relation to essential notification requirements including reporting under Section 31 of the Health and Disability Services (Safety) Act 2001. Three notifications have been made to the Ministry of Health since the last audit. One was with regard to the additional room and the other two were to advise the Ministry of the shortage in registered nurses (refer standard 1.2.8).</p> <p>All adverse events are documented. Records of events sampled confirmed that the immediate actions and investigation were completed in an appropriate and timely manner. Remedial actions and improvements are made. There was evidence of open disclosure where required. A summary of adverse events is maintained and reported monthly. The year to date summaries were sampled and confirmed collation and trending by category, with a full analysis of each event category.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Policies and procedures identify good employment practice; reflect good practice and meet requirements. Job descriptions describe staff responsibilities and accountabilities.</p> <p>There is an orientation process. The orientation programme includes the essential components of service delivery and emergency management. Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in staff files sampled.</p> <p>There is an annual education calendar for on-site education. Mandatory topics are defined and include: consumer rights; infection prevention and control; manual handling; restraint and emergency management. Additional in-service and outsourced education is available to staff. There are currently three registered nurses who have completed interRAI training. All of the registered nurses have a current first aid certificate. The cleaners have had chemical safety training and all kitchen staff are scheduled to complete an update on their food handling requirements in response to the changes in food safety legislation.</p> <p>An improvement is required regarding annual performance appraisals.</p>
Standard 1.2.8: Service Provider	FA	Policy related to staff skill mixes and experience is reflected in the roster to meet and exceed contractual requirements. There is a combination of 12 and eight-hour shifts. Care givers and registered nurses are provided

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>with set numbers of residents on their duty/task lists. There are sufficient staff on duty per rostered shift, with five care givers in the morning, four until 11pm and two care givers overnight. There are three registered nurses rostered on the morning shift, two in afternoon, and one at night. There are designated additional service staff such as: cleaners; laundry; activities and kitchen staff.</p> <p>There is evidence that gaps in the roster are filled. It was reported by management that in the event a gap in the roster that could not be filled there are still sufficient staff to safely cover shifts. Regular team meetings and registered nurse handovers/meetings ensure continuity between shifts. The nurse manager and the operations manager are on site Monday to Friday during business hours and on call at all times.</p> <p>The number of employed registered nurses has reduced from 11 to four, plus the nurse manager. This has meant that the nurses are having to complete additional shifts to ensure there is a registered nurse on site at all times. The organisation has been actively recruiting for additional nurses and has alerted the Ministry of Health.</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 Moderate</p>	<p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. An electronic medication management system is used. Medications are stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the registered nurses when the resident is transferred back to service from hospital. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated, and photos current for easy identification.</p> <p>A medication competency is completed for all nurses administering medication. The RN was observed administering medicines following the required medication protocol guidelines and legislative requirements. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted. A pharmacist completes the six-monthly controlled drug (CD) stock take. Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal are reported and attended to promptly. The service does not keep any vaccines. All expired medications are returned to the pharmacy in a timely manner. The operations manager completes a weekly audit on the medication management system.</p> <p>An improvement is required regarding stocked medication and residents who are self-administering inhalers.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs</p>	<p>FA</p>	<p>Meal services are prepared on site and served in the allocated dining rooms. The facility employs two cooks who are assisted by kitchen hands. The menu has been reviewed by the registered dietitian. There is a six-weekly rotating menu in place. Diets are modified as required and the cooks confirmed awareness on 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. The family members interviewed acknowledged satisfaction with the food service.</p> <p>The kitchen was audited and registered under the food control plan. The kitchen and pantry were sighted and</p>

are met where this service is a component of service delivery.		observed to be clean, tidy and stocked. Labels and dates were on all containers. Records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	All care plans are resident centred, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short-term care plans for acute needs. The residents and family interviewed confirmed care delivery and support is consistent with their expectations and plan of care. The previous area requiring improvement relating to addressing clinical assessment protocols in the care planning process has been addressed.
<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	Care plans sampled confirmed that interventions are adequate to address the identified needs in the care plans. Significant changes are reported in a timely manner and prescribed orders carried out. The RN reported that the GPs' medical input is sought in a timely manner, that medical orders are followed, and care is person centred. Care staff confirmed that care is provided as outlined in the care plan. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Residents' diversional therapy assessment and diversional therapy care plan are completed on admission in consultation with the family and residents where able. The activities coordinator reported that routine six monthly diversional therapy care plans reviews are completed in conjunction with interRAI assessments and this was sighted in files sampled.</p> <p>Activities are provided in individual or group settings. Activities are varied and appropriate for residents in the rest home, hospital wing and residents under 65 years. The residents were observed to be participating in a variety of activities during the audit. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents and family members interviewed reported overall satisfaction with the level and variety of activities provided.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented on each shift by care staff in the progress notes. The registered nurses complete progress notes daily and as necessary. All noted changes by the care staff are reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes is completed. Evaluations are carried out by the RNs in conjunction with family, GPs and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The facility is purpose built and has been well maintained. The current building warrant of fitness is displayed. The operations manager has oversight of the maintenance programme. There is also a maintenance person on site Monday to Friday.</p> <p>Medical equipment is fit for purpose and calibration reports for medical equipment were sighted. Floorings, furnishings and fittings were well maintained. Corridors are wide and residents were observed to be safely passing each other; safety rails are secure and are appropriately located.</p> <p>External areas and decks are available for residents and these are maintained to a good standard with one of the decks recently being replaced. Residents are protected from risks associated with being outside including provision of adequate and appropriate seating and shade; and ensuring safe areas are available for recreation or evacuation purposes. External hazards are identified and isolated.</p> <p>The previously identified area requiring improvement has been addressed. Routine inspection of electrical equipment has been completed. The operations manager has been authorised as competent to complete local testing and tagging.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that</p>	PA Negligible	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data was until recently being reported and collated monthly, however this system has not been maintained due to the reduction in nursing staff. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively</p>

have been specified in the infection control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Warkworth Hospital actively works to minimise the use of restraint. The policy provides consistent definitions for restraints and enablers. The service currently has no residents using restraint and one resident was using an enabler for safety and comfort. Staff receive ongoing education on the use of restraint and challenging behaviours. The assessment, approval, monitoring and review process is the same for both restraints and enablers. A restraint register was sighted. In interview conducted, staff demonstrated awareness on the difference between a restraint and an enabler.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	The organisation aims to provide up to 10 in-service education sessions per year. At the time of the audit eight (8) in-service sessions had been provided for the year to date. There is still some difficulty in ensuring staff attendance at some of these education sessions, however this is being monitored by management. The organisation is in the process of engaging in the services of an external organisation to help manage human resources as this have been difficult to maintain during the last year due to reduced RN staffing and consent/construction processes which have taken priority. This has resulted in lapse of completing, or maintaining records of, annual performance appraisals.	Records of the required annual performance appraisals were not evident in all staff records sampled.	<p>Provide evidence of annual performance appraisals.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to</p>	PA Moderate	It was observed during the medication administration round that some medication for rest home residents was being administered from stock. This included regular and ‘as required’ paracetamol which had been	Not all medication being	Medication for rest home residents to

manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		dispensed from the pharmacy in a large container.	administered had been individually prescribed.	be individually prescribed. 60 days
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	There were two residents who were self-administering inhalers but had not been assessed as competent. A self-medication policy is in place. Medication administration records were maintained.	There is no documented evidence that residents who are self-administering prescribed inhalers have been assessed as competent to do so.	Complete self-administration competencies for all residents who are self-administering. 60 days
<p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>	PA Negligible	There is evidence that infections are discussed, and the RN interviewed confirmed that there has been some infections over the last few months, however records of infection events and monthly infection surveillance reports are not being completed. The previous infection control coordinator, who was a registered nurse is no longer with the organisation and this position is yet to be filled.	The infection control surveillance programme has not been maintained monthly as required.	Reinstate the infection control surveillance programme. 60 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.