Waverley Aged Care Limited

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:	Waverley Aged Care Limited
Premises audited:	Waverley House Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 February 2015 End date: 12 February 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 19

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

Waverley House is certified to provide rest home level for up to 20 residents. On the day of the audit there were 19 residents. The rest home has been operated by a husband/wife team for ten years. They are supported by a registered nurse.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff

The service has addressed seven of the eight shortfalls from their previous surveillance audit around policy reviews, internal audits, surveys and results, performance appraisals, initial assessments, evaluations, medication documentation and medication competencies. Further improvements continue to be required around dietitian review of the menu.

This audit also identified improvements around currency of policy content, family notification post incidents, audit corrective actions, restraint documentation, care interventions, fridge and freezer temperatures and functional check of the hoist.

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

Waverley House practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights "the Code" and copies of the code are displayed in the main entrance. There is a complaints policy supporting practice. There have been no complaints since the previous audit. There is an improvement required around family notification following accidents/incidents.

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.

The 2014 business plan is under review with goal setting in progress for 2015. The service has reviewed its policies and procedures. The internal surveys have been collated and communicated to participants. Quality, health and safety and infection control are set agenda items at the quality/staff meetings. Staff interviewed confirmed they are kept informed on risk management matters. There is an internal audit programme in place. Accidents/incidents are collated monthly and results are available to staff.

Newly employed staff have completed an orientation programme. The education planner covers compulsory training requirements for aged care.

There are improvements required around audit policy content to meet current best practice and internal audit corrective actions.

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.

The residents' needs, interventions, outcomes/goals have been identified and these were reviewed on a regular basis with the resident and/or family/whanau input. Care plans demonstrate service integration. Care plans are reviewed six monthly, or when there are changes in health status. There is an improvement required around care interventions. Resident files include notes by the GP and allied health professionals.
Medication policies and procedures were in place to guide practice. Education and medication competencies were completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and intolerances.
The activities programme is facilitated by a diversional therapist. The activities programme provides varied options and activities are enjoyed by the residents. The programme meets the individual recreational needs.
All food is cooked on site by the in-house cook. All residents' nutritional needs were identified, highlighted and choices available and provided. Meals were well presented. There is an improvement required around fridge and freezer temperature monitoring. The previous finding around dietitian review of the menu remains.

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

The building has a current warrant of fitness. There is an improvement required around annual hoist checks.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

There are comprehensive policies and procedures that meet the restraint standards. The registered nurse is the restraints co-ordinator and has recently formed a restraint approval group that will meet three monthly. The restraint coordinator provides a monthly report to the quality/staff meetings. There is one resident with restraint and no enablers in use on the day of audit. There is an improvement around the implementation of restraint documentation. Restraint training has been provided annually.

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.

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The registered nurse is the infection control co-ordinator. The Infection Control co-ordinator reports monthly surveillance data to the quality/staff meetings. All staff receive infection control education on orientation and annually. Internal audits have been completed with documented outcomes known to staff. The Infection control coordinator is scheduled to attend district health board training in April 2015. Infection control education is provided on orientation and annually.

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	11	0	4	2	0	0
Criteria	0	36	0	5	3	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 service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. The manager is responsible for complaints management. There have been no complaints since July 2013. The only complaint was appropriately investigated and managed. A complaints register is maintained. The code of rights, advocacy brochure and complaints forms are displayed in the main entrance. To caregivers and one RN interviewed are knowledgeable in the complaints/concerns procedure. D13.3h. A complaints procedure is provided to residents within the information pack at entry. Discussion with residents and relatives confirmed they were provided with information on complaints are comfortable approaching management with any concerns/complaints.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	The manager and registered nurse (RN) are readily available to relatives and residents as observed on the day of audit. Relatives (three) and residents (three) interviewed confirmed that the staff and management are approachable and available. There are resident meetings held three monthly with opportunity for feedback on the services. Resident and relative surveys have been completed

		annually. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry. Relatives and residents interviewed stated they were given sufficient information prior to entry to the service and had the opportunity to discuss services and the admission agreement with management. D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D11.3 The information pack is available in large print and advised that this can be read to residents. Interpreter services are available as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Waverley House is a 20 bed rest home facility. On the day of audit there were 19 rest home residents. The manager leases the building and the business is operated by a wife (manager) /husband (maintenance). The manager is non-clinical and has had many years' experience managing rest homes. ARC, D17.3di (rest home). The manager has maintained at least eight hours annually of professional development activities related to managing a rest home. The manager is supported by a RN Monday to Friday and on-call. The RN is newly appointed December 2014 after graduating with a Bachelor of Nursing. She has links into the district health board (DHB) for nursing advice, clinical support and education. There is a 2014 business plan and goals that is currently under review. The medication system including administration, reduction of errors and staff education has been the focus for the RN over the last two months. There is evidence of a robust medication system with no findings on the day of audit.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system	PA Low	There are policies to guide the facility to implement the quality management programme including (but not limited to); quality and risk management programme, committee responsibilities and internal audit schedule. The 2014 internal audit programme has been followed and results discussed at staff meetings. This is an

that reflects continuous quality improvement principles.		improvement since the previous audit; however improvements are required around corrective actions. The quality review team (manager, RN and senior caregiver) provide reports to the monthly staff meetings. Minutes sighted evidence there is discussion around resident concerns, health and safety, infection control, audit and survey results, corrective actions and improvements. Staff interviewed state they are well informed and receive quality and risk management information at staff meetings. The diversional therapist (DT) conducts surveys six monthly (February and August) as follows: resident care, food satisfaction and activities. The results have been collated and discussed at the resident meetings as evidenced in meeting minutes. This is an improvement since the previous audit. D5.4. The policies and procedures in place have been reviewed 2014. This is an improvement from the previous audit. Further improvement is required around the contents of policies and procedures. D19.3: There is a Quality and Risk management programme in place that includes emergency and disaster planning, health and safety and hazard identification. Staff report any hazards identified on the daily maintenance request/hazard form. D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Prevention strategies (hi-low beds and sensor mats) and corrective actions are documented in the residents care plan.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is evidence of month by month data collection including (but not limited to): falls, falls with injury, skin tears, medication, behavioural incidents and pressure areas. Falls management and prevention includes corrective actions and monitoring requirements which are linked to the long term care plans such as the use of a hi-low bed and sensor mats (link 1.3.6.1). The RN investigates and reviews and implements corrective actions as required of all accident/incident forms. The caregivers interviewed could describe the process for reporting of incidents and accidents. D19.3b; There is an accident/incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action. D19.3c; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Discussions with service management, confirms an

		awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files reviewed contained relevant recruitment documents and completed orientations. Annual appraisals were up to date. This is an improvement since the previous audit. The RN practising certificate was sighted. Monthly staff training occurs at the staff meetings. The 2014 training plan has been completed and covered compulsory requirements and clinical topics. The 2015 training plan has commenced. The RN is scheduled for InterRAI training March 2015. Competencies are identified and completed. Staff responsible for medication administration complete annual competencies. All staff have current first aid. D17.8 Eight hours of staff development or in-service education has been provided annually.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Staffing rosters were sighted and there was an adequate number of care staff on duty to meet the resident's needs on different shifts. There is a cook on duty daily and a dedicated cleaning/laundry person Monday to Sunday. The RN is on duty six hours a day Monday to Friday and on call after hours and weekends. Residents and relatives interviewed confirm that there is sufficient staff on site at all times. Caregivers interviewed state there is adequate staff on duty at all times.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are medication policies in place. All medication administering follows safe medication guidelines as set down in the policies. All medication competent caregivers must refer to the registered nurse prior to administrating as required medications (PRN). The registered nurse is on-call seven days a week. Medication fridge temperatures are monitored weekly. Medication reconciliation is completed on admission and the policy includes guidelines on checking medications on arrival. All staff administering medications have completed an annual medication competency.

		This is an improvement since the previous audit. At the time of audit there were no residents' who were self-administering medications. Ten medication charts were reviewed. All meet GP prescribing meet legislative guidelines and signing on administration charts are documented accurately. There is no evidence of transcribing. The previous audit finding around medication documentation, expired medications and medication charts has now been addressed.
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.	PA Moderate	Waverly House Rest Home has a well equipped kitchen. There is a four week rotational menu in place that has not been reviewed All meals are prepared in the main kitchen and served from the kitchen directly to the residents' in the main dining room. Diets are modified as required. The cook confirmed that there is an alternative available. Any changes to nutritional requirements are communicated to the cook by the registered nurse. Kitchen fridge, freezer and food temperatures are not regularly monitored and documented.
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	Five resident files were reviewed. The care plans included interventions to support care needed. All residents' interviewed stated their needs were being appropriately met. Dressing supplies are available and a treatment room is stocked for use. Procedures for wound assessments, evaluation and nursing interventions were in place as evidenced in the wound management folder. On the day of audit there were three wounds identified. There were no pressure areas. Continence products are available and were identified for daytime and night use, plus any other management. However, there were no continence or pain assessments in the resident files reviewed. This is an area for improvement. Short term care plans were utilised when required. Any changes to the long term care plan were dated and signed by the registered nurse.
Standard 1.3.7: Planned Activities	FA	One diversional therapist is employed for 22 hours a week. An activities programme

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.		is provided over five days each week. The programme is planned monthly and residents receive a personal copy of planned monthly activities. A diversional therapy plan was developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities. Residents were observed participating in activities on the day of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Short term care plans were utilised when required. Any changes to the long term care plan were dated and signed by the registered nurse. Care plans reviewed had been evaluated six monthly, or as needed. This is an improvement since the previous audit. There is at least a three monthly review by the general practitioner. Changes in health status are documented in progress notes and reflected in care plans.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	There is a current building warrant of fitness expiring 16 November 2015.
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	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator is the RN. Information obtained through surveillance is used to plan and determine infection control activities, resources and education needs within the facility. A monthly analysis of types of infections, signs and symptoms, interventions, trends, corrective actions and quality initiatives is reported to the monthly quality/staff meetings. Surveillance types and numbers are available to staff. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The RN is the restraint coordinator. The policy identifies that restraint is used as a last resort. The service currently has no residents on enablers and one

		resident on restraint (bedrails).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Moderate	The RN is the restraint coordinator. An approval group has been formed with defined responsibilities including the approval, assessment and review of restraints. Restraint education and discussion occurs at staff meetings. A restraint register is maintained.

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 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Relatives interviewed stated that they are informed when their family member’s health status changes. They have the opportunity to attend the general practitioner visits and are involved in the residents care plans and reviews.	There was no documented evidence of relative notification for eight accidents/incidents (including three falls with head injury) in the month of January 2015	Ensure open disclosure is practiced regarding accidents/incidents. 30 days
Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.	PA Low	There are policies and procedures in place to guide staff in the safe delivery of care. These have been reviewed 2014 which is an improvement since the previous audit. Staff are required to sign a form declaring they have read new/reviewed policies.	Policies and procedures in use were issued in 2003. There are 2014 review dates, however the content of the policies and procedures have not been reviewed to meet current best practice.	Ensure policies and procedures are reviewed to meet current best practice. 180 days

Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	Internal audit corrective actions and recommendations are identified for the majority of audits with shortfalls.	Corrective actions have not been implemented for (i) food services audit (June 2014) identified dietitian review of the menu was required (link 1.3.13) and (ii) pain management audit (August 2014) identified staff required pain management education.	Ensure corrective actions are implemented as recommended. 90 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Moderate	All meals and baking is prepared and cooked on site. Residents interviewed commented positively on the meals. The menu requires review.	A food service audit (June 2014) identified the menu required a review (link 1.2.3.8). The review had not been undertaken or scheduled at time of audit. The previous finding around dietitian menu review remains.	Ensure the menu is reviewed by a dietitian. 90 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	Kitchen is maintained in a clean and hygienic manner. The fridges and freezers are clean, with food covered and dated.	There is no documented evidence of any regular fridge and freezer temperature monitoring taking place.	Ensure there is regular monitoring of fridge and freezer temperatures. 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	PA Low	Continence products are available to those residents who need them and all five resident files reviewed documented the use of continence products. There is evidence of timely interventions by the registered nurse and general practitioner for those who require	(i)There were no continence assessments in the resident files reviewed. (ii) There were no pain assessments documented in the files of residents with identified pain. There was no documented evidence of the monitoring of the effectiveness of pain relief. (iii)	(i) To ensure continence assessments are completed for all residents in the rest home. (ii) To ensure pain assessments are completed for all residents who identified as reporting pain. Ensure the effectiveness of pain relief is monitored. (iii) Ensure appropriate

outcomes.		pain relief, this was documented in the four files for resident who have documented evidence of pain. Eight falls (witnessed and unwitnessed) sampled for the month of January 2015 were reported on the accident/incident formed and reported to the RN.	Three falls with head injury did not have neurological observations completed.	assessments are completed following falls with head injury. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The service has a range of equipment available. Staff report that reactive and preventative maintenance is carried out.	The hoist has not had a mechanical check in the last year.	Ensure there is mechanical check of the hoist. 90 days
Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated;	PA Moderate	There is one resident on restraint (cot sides) since October 2014. An assessment has been completed.	The consent form has not been signed by the GP or relative. The uses of restraint and associated risks have not been included in the resident care plan. There is no evidence or record of restraint monitoring or observations during each period of restraint.	Ensure restraint is applied in line with restraint policies and procedures. 30 days

(d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.				

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.