# Thornton Park Retirement Lodge 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Thornton Park Retirement Lodge Limited

**Premises audited:** Thornton Park Retirement Lodge

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 28 April 2015 End date: 29 April 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:** 35

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Thornton Park is a privately owned facility. The service provides rest home and hospital care for up to 42 residents. On the day of audit there were 35 residents. The service is operated by a clinical nurse manager/registered nurse who has been with the service five years and has experience in aged care. She is supported by a non-clinical support services manager and a 24/7 registered nursing team.

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. Residents and families comment positively on the care and services provided at Thornton Park.

The service has addressed one of five shortfalls from their previous certification audit around self-medication.

Further improvements continue to be required around resident/family input into care plans, documentation of interventions and defined responsibilities for infection control and restraint.

This audit identified an improvement required around meetings, communication of quality data, annual resident/relative surveys, performance appraisals, review of the business goals, activity plans, enabler reviews and aspects of medication documentation.

## Consumer rights

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| 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. |

Family are informed when the resident health status changes. There is a documented process for making complaints and residents and family were able to discuss the complaints process. Complaints are recorded in an on-register.

## Organisational management

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| 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. |

Thornton Park has a quality and risk management system that supports the provision of clinical care. Quality data collection including infections, accidents/incidents and internal audit outcomes are entered into the on-line system.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. An external registered nurse educator implements an annual education plan that covers training requirements. The staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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| 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. |

Registered nurses are responsible for care plan development with input from residents and family. Initial assessments, risk assessments, care plans and evaluations in resident files were completed within the required timeframes. Residents and family interviewed confirmed that the care provided meets the residents' needs. The general practitioner reviews the residents three monthly.

Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme.

Medication policy and procedure aligns with legislation and current regulations. The previous finding around self-medication had been addressed.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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| 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. |

Thornton Park has a current building warrant of fitness.

## Restraint minimisation and safe practice

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| 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 low risk. |

The service has policies and procedures to appropriately guide staff around consent processes and the use of enablers. There were three enablers and two restraints in use. Staff receive training in restraint as part of the annual training plan.

## Infection prevention and control

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

There is an infection control policy that includes surveillance activities. The surveillance programme is appropriate to the size and complexity of the facility. Infections are collected and collated monthly.

## Summary of attainment

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

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| **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 | 8 | 0 | 7 | 3 | 0 | 0 |
| **Criteria** | 0 | 31 | 0 | 7 | 3 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **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 | There is a complaints policy to guide practice. The support services manager leads the investigation and management of complaints (verbal and written). The clinical nurse manager is involved in any clinical concerns/complaints. There is an up to date on-line complaints register. There have been no complaints/concerns received since the previous audit. Complaints forms are available. Discussion with residents (three rest home and one hospital) and relative’s state management operate an open door policy and were aware of how to make a complaint.  D13.3h: A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Twenty one incident forms were reviewed from March 2015 period. All forms evidence family have been informed of an accident/incident. Interview with one clinical nurse manager, one registered nurse (RN) and three caregivers confirm family are notified following changes in health status.  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 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. D16.4b Relatives (one hospital and one rest home) stated that they were informed when their family members health status changes. D11.3 The information pack is available in large print and this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | Thornton Park provides rest home and hospital level of care for up to 42 residents. There were 16 rest home and 19 hospital level residents (including five younger persons – two with long term chronic conditions and three young people with disabilities) on the day of audit.  The service is privately owned. The clinical nurse manager has been in the role for five years and holds a bachelor’s degree and a postgraduate certificate in nursing. She is supported by 24/7 registered nurses. There is a non-clinical support services manager. Both managers are responsible for the daily operations of the service. The clinical nurse manager provides a monthly report to the directors.  There is an improvement required around the review of the business plan.  ARC,D17.3di: (rest home), D17.4b (hospital): The clinical nurse manager has maintained at least eight hours annually of professional development activities related to managing a rest home/hospital. |
| 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. | PA Low | The risk management plan and risk assessments have been reviewed. Policies and procedures are being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. New/reviewed policies are available on-line for staff to access.  There is an internal audit schedule that includes environmental and clinical audits. The clinical nurse manager completes audits in consultation with the relevant key person. Quality investigation forms are raised for any service shortfalls and signed off on completion.  D19.3: There are health and safety policies in place to guide practice. There is a current hazard register. The service has an occupational health and safety (OSH) officer who has completed a recognized qualification in accident investigation.  D19.2g: Falls prevention strategies are in place.  There is an improvement required around surveys, communication of quality data and meetings. |
| 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 | D19.3c: The service collects incident and accident data which is collated monthly and entered into the on-line system (link 1.2.3.6). Incident forms are completed by staff. The RN reviews and assesses the resident at the time of event and the form is forwarded to the clinical nurse manager. Twenty one incident forms were reviewed and were seen to have been completed and closed off (link 1.3.6.1). Incidents/accidents are recorded in the progress notes.  Discussions with service management, confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no reportable events. |
| 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 to support recruitment practices. Annual practising certificates sighted were current. Five staff files were reviewed and contain all required documentation except performance appraisals.  The service has an orientation booklet in place that newly appointed staff complete and these were sighted in the staff files sighted.  The services employs an external educator (RN) who is responsible for the development and coordination of the education programme. Caregivers and one registered nurse (RN) interviewed state they attend on-site in service and have the opportunity to attend external education.  Staff complete competencies/questionnaires relevant to their role. There is a staff member with a current first aid certificate on every shift. |
| 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 are policies, procedures and guidelines that align with contractual requirements and include skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Residents and relatives confirm there are sufficient staff on duty at all times. There is a registered nurse on duty 24/7. The clinical nurse manager provides on-call after hours. |
| 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 | Medication administration meet the guidelines for safe medicine management. All medications were checked in on delivery. RNs responsible for the administration of medication have completed medication education and competencies. All administration signing sheets sampled (10) were completed correctly. There are no standing orders. There were no self-medicating residents. The previous finding around self-medication has been addressed.  Ten medication charts were sampled. There is an improvement required around medication charts. |
| 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 meals at Thornton Park are prepared and cooked on site. There is a four weekly seasonal menu developed and monitored by the Kitchen coordinator (qualified chef). A dietitian review is underway. There is a cook and kitchen hand on duty each day. A dietary sheet is received from the RN for new residents and for any resident dietary changes. Resident likes and dislikes are known and alternative foods offered. Resident meetings allow for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicate satisfaction 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 Moderate | A written record of each resident’s progress is documented. When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. Contact with relatives regarding resident changes were sighted in the progress notes. Relatives were notified of any incident/accidents as evidenced on the incident/accident forms.  Dressing supplies were available and treatment rooms well stocked for use. Wound map, assessment and wound dressing records have been completed for three skin tears, one minor wound and one chronic wound. The one chronic wound is linked to the long term care plan. Wound care and continence advice is available as needed.  The previous shortfall remains around the documentation and implementation of interventions. |
| 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. | PA Low | The activity coordinator provides an activity program over four days a week which is flexible to meet the resident’s recreational preferences. The daily programme is written up on the board and residents are kept informed of activities happening throughout the week. Resident suggestions for outings, activities and entertainers are fed back through daily discussion. One on one time is spent with residents who are unable to or do not choose to participate in the activity programme. The service has two vans, one with wheelchair access for outings. Maintaining community links are encouraged. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Written care plan evaluations were completed for four out of five resident files and long term care plans updated with changes. One hospital resident had not been at the service six months. Care staff stated the RN involved them in the review of resident care plans. The GP completes three monthly medical reviews. |
| 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 facility displays a current building warrant of fitness which expires on 24 June 2015. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | PA Moderate | The previous audit identified that responsibilities for the infection control coordinator were not clearly defined. This has not yet been addressed. |
| 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. All infections are entered onto an on-line infection data base with comparative monthly infection rates. Surveillance infection control rates are collated and graphed. There is no documented evidence of discussion at staff meetings around infection control rates, trends identified and corrective actions (link 1.2.3.6). The infection control coordinator (clinical nurse manager) uses the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. There is close liaison with the GP that advises and provides feedback /information to the service. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | PA Low | There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The policy identifies that restraint is used as a last resort. There are three enablers and two restraints in use. Enabler use and assessments have not been reviewed. Restraint minimisation education is provided annually. A resource folder was available to staff. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | PA Low | Responsibility for restraint coordination has not been clearly defined to identify responsibilities for the role including reporting and monitoring or enablers and restraints in use. This continues to be an improvement from the certification audit. |

# 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.

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | Thornton Park’s mission is to “provide quality care in a loving family-like environment”. The service has local long serving staff caring for local people. Staff, residents and family confirmed the service provides a family environment. | There is no evidence that the business plan and quality goals have been reviewed regularly. | Ensure the goals of the organisation are reviewed regularly.  180 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Infection events, accident/incidents and internal audits are completed and collated monthly and entered into the on-line system. Internal audits are completed as per schedule. A resident/relative survey was conducted September 2013. | (i) Monthly quality meetings, staff meetings and RN meetings have not occurred as per schedule. (ii) There was no documented evidence of quality data including infections made available to staff or discussed in staff meetings. (iii) The annual resident/relative survey has not been completed for 2014. | Ensure meetings are held as scheduled, the annual resident/relative survey is completed and quality data is discussed and documented in the meeting minutes.  60 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 | The performance appraisal system identifies education needs on an individual basis. | Five of five staff files sampled did not have an annual appraisal completed. | Ensure staff appraisals are conducted annually.  180 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 | Ten medication charts sampled had been reviewed by the GP three monthly. | i) Five out of ten medication charts did not have each medication dated. ii) Two out of ten medication charts did not identify an allergy status. iii) Five out of ten medication charts did not have photograph identification. | Ensure medication charts meet legislative requirements.  60 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | Five care plans sampled were developed and reviewed by the RN. There is evidence of allied health input into residents care as required by referral such as physiotherapy, speech language therapist, diabetes clinic and mental health services. | Four of five care plans did not evidence resident/family/whanau involvement in the care planning process. | Ensure there is written evidence of resident/family/whanau participation in the care planning process.  90 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 Moderate | Short term care plans are utilised for short term needs. Changes to resident health status are discussed at handovers. | i) High falls risk status has not been reflected in the long term care plan for two hospital residents (link hospital tracer).  ii) There were no neurological observations for two hospital residents post fall with head injury.  iii) There was no pain assessment for one hospital resident with new episode of pain (link hospital tracer).  iv) There was no short term care plan for a minor wound. | i) Ensure interventions are documented to reflect resident’s current health status.  ii) Ensure neurological observations are completed post head injury.  iii) Ensure pain assessments are completed for residents with new pain so appropriate interventions can be identified.  iv) Wound management timeframes to be met for all wounds.  90 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Residents were observed participating in activities on the days of audit. Residents and family members interviewed enjoyed the activities offered. Progress notes of individual resident participation was maintained in the integrated file. | Three resident activity plans (two hospital and one rest home) have not been reviewed six monthly. The activity plans have not been reviewed at the same time as the care plans. Two residents (one rest home and one hospital) did not have activity plans in place. | Ensure activity plans are in place for all residents and are reviewed six monthly at the same time as the care plan.  90 days |
| Criterion 3.1.1  The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management. | PA Moderate | The clinical nurse manager is the infection control coordinator. | The responsibilities for the infection control coordinator are not clearly defined. | Ensure the responsibilities for the infection control coordinator are clearly defined.  90 days |
| Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | There are three residents with an enabler. Consent forms have been voluntarily signed by the residents. | Enabler use and enabler assessment has not been reviewed six monthly as per policy. | Ensure enabler use is assessed six monthly.  60 days |
| Criterion 2.2.1.1  The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. | PA Low | The restraint coordinator is a registered nurse. | Responsibility for restraint coordination has not been clearly defined. This continues to be an improvement from the certification audit. | Ensure the restraint coordinator’s role and responsibilities are clearly defined.  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.

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End of the report.