

# Oceania Care Company Limited - Melrose Park

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## Introduction

This report records the results of a Certification 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 Audit (NZ) 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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Melrose Park Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 18 May 2015    End date: 19 May 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	75

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Melrose Park Home & Hospital (Oceania) can provide care for up to 87 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

Improvements are required to privacy for residents sharing rooms and initial medical assessments for new residents.

## 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.
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Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their

dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained. The service is located close to community facilities and residents can access these as able.

The service has a documented complaints management system implemented. There were no outstanding complaints at the time of audit.

The service is required to put curtains in bedrooms shared by residents to ensure privacy between beds.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation's mission statement and vision have been identified in the business plan. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents' needs. The management team regularly reviews the business, risk and quality plans.

The quality and risk system and processes supports safe service delivery. The quality management system includes an internal audit process, complaints management, resident and relative satisfaction surveys, incident/accident and infection control data analysis. Corrective action planning is implemented with evidence of resolution of issues. Quality and risk management activities and results are shared among staff. Reporting processes include external benchmarking.

There are human resource policies implemented around recruitment, selection, orientation and staff training and development. Staff identified that staffing levels are adequate and interviews with residents and relatives demonstrated that they have adequate

access to staff to support residents when needed. Staff are allocated to support residents as per their individual needs. The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and regional and executive management team. Service delivery is monitored. Staffing levels are reviewed for anticipated workloads and acuity.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The services policies and procedures provide guidelines for access to service. Timeframes for nursing service delivery are met and include input from residents, families, and allied health professionals, however, there is an improvement required to ensure medical assessment of new residents is completed within the required timeframe. Initial assessment, care and support are provided by competent staff, with ongoing evaluations completed by a registered nurse. Nursing interventions are consistent with best practice and care plans well utilised.

There is a broad range of activities which are appropriate for the service users. Residents and families interviewed confirm they are well supported to maintain interests and participation is voluntary.

The service has a documented medication management system which meets all requirements, and staff assessed as competent to manage medications.

Nutritional needs are met. Special dietary requirements are catered for and regular monitoring completed. Food services and storage meet food safety requirements.

## 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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All building and plant complies with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes equipment and electrical checks. The environment is appropriate to the needs of the residents. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allows residents to access help when needed in a timely manner.

## 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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There are documented guidelines for the use of restraint and enablers, and managing challenging behaviours. Staff receive training and demonstrated an understanding of the appropriate and safe use of restraint and enablers to maintain independence

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection prevention and control policies and procedures are adequately documented. There is a designated infection control co-ordinator who is responsible for ensuring monthly surveillance is completed and monitoring of infection control practices. Documentation sighted provides evidence that all staff are educated as part of an initial orientation and as part of on-going in-service education

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	48	0	2	0	0	0
<b>Criteria</b>	0	99	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility and in each residents room. New residents and families are provided with copies of the Code as part of the admission process.</p> <p>Staff are provided with annual training around rights and the Code. The clinical staff were observed to implement rights as per the Code in their day-to-day practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.</p> <p>All resident files identified that informed consent was collected.</p> <p>Interviews with staff confirmed their understanding of informed consent</p>

		<p>processes.</p> <p>The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discusses informed consent processes with residents and their families/whānau during the admission process.</p> <p>The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files noted that all had appropriately signed advanced directives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service.</p> <p>Staff training on the role of advocacy services is included in training on The Code of Health and Disability Consumers' Rights with this provided annually to staff.</p> <p>Discussions with family and residents identifies that the service provides opportunities for the family/EPOA to be involved in decisions and they stated that they have been informed about advocacy services.</p> <p>The resident files includes information on residents family/whanau and chosen social networks with a communication sheet kept on the resident file and completed when family visit or phone.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and family/whānau are encouraged to visit at any time. The family report there are no restrictions to visiting hours.</p> <p>Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme.</p> <p>The facility is close to community facilities and residents report they are</p>

		encouraged to access these independently as able.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints.</p> <p>Complaints management is explained as part of the admission process for residents and family/whānau and is part of the staff orientation programme and ongoing education.</p> <p>Residents and family/whānau confirmed that the management's open door policy makes it easy to discuss concerns at any time. The complaints register records the complaint, dates and actions take, these are addressed to comply with right 10 of the Code. There are no outstanding complaints at the time of audit.</p> <p>Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur.</p> <p>There have been no complaints lodged with external authorities since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The business and care manager, clinical manager or a registered nurse discussed the Code, including the complaints process with residents and their family on admission.</p> <p>Discussions relating to the Code are also held at the resident meetings.</p> <p>Residents and family interviews confirmed their rights were being upheld by the service.</p> <p>Information regarding the Health and Disability Advocacy Service is clearly displayed in the foyer of the facility.</p> <p>The resident right to access advocacy services is identified for residents and advocacy service leaflets are available at the entrance to the service. If necessary, staff could read and explain information to residents as stated by the health care assistants and registered nurses</p>

		<p>interviewed.</p> <p>Information is was also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.</p> <p>Residents and family members are able to describe their rights and advocacy services particularly in relation to the complaints process.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>PA Low</p>	<p>The service has a philosophy that promotes dignity and respect and quality of life. Resident support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values with care plans completed with the resident and family member (confirmed by residents and family interviewed).</p> <p>Interventions to support these are identified and evaluated.</p> <p>Residents are addressed by their preferred name and this is documented in files reviewed.</p> <p>A policy is was available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour.</p> <p>The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which could be used for private meetings.</p> <p>Health care assistants interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families confirm the residents' privacy is respected.</p> <p>Health care assistants interviewed reported that they encouraged the residents' independence by encouraging them to be as active as possible. A physiotherapist is was available during the week to help with independence.</p>

		<p>Bed rooms are either single, two-bed or four-bed occupancy. The service has completed the refurbishment of some four-bed rooms into two bedrooms with curtains able to be pulled so that residents cannot be seen from the hallway. The curtains do not separate the two resident bedrooms entirely.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service implements the Maori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan.</p> <p>Links to local kaumatua are documented.</p> <p>There is one Maori resident living at the facility during the audit. There are staff who identify as Maori and they are able to articulate their role in supporting residents who identify as Maori.</p> <p>Staff reported that specific cultural needs are identified in the residents' care plans and this was sighted in files reviewed.</p> <p>Staff are aware of the importance of whanau in the delivery of care for the Maori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies each resident's personal needs from the time of admission. This is completed with the resident, family and/or their representative having input into the admission, assessment and planning processes.</p> <p>There is a culture of choice with the resident determining when cares occur, times for meals, choices in meals and choices in activities. Health care assistants were able to give examples of how choices are given to residents who had non-verbal ways of communicating.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment,</p>	FA	<p>The staff files have job descriptions, employment agreements and staff handbooks that have clear guidelines regarding professional boundaries. Families and residents reported they are satisfied with the</p>

<p>sexual, financial, or other exploitation.</p>		<p>care provided. The families expressed no concerns with breaches in professional boundaries, discrimination or harassment.</p> <p>The orientation and employee agreement provided to staff on induction includes standards of conduct.</p> <p>Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the health care assistants' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are policies and procedures to guide practice. These policies align with the health and disability services standards and are reviewed bi-annually. A quality framework supports an internal audit programme. Benchmarking occurs across all Oceania facilities.</p> <p>There is a training programme implemented. Staff described sound practice based on policies and procedures, care plans and information given to them via the registered nurse.</p> <p>There is a training programme for all staff and manager's are encouraged to complete management training. There are monthly regional management and clinical meetings attended by the business and care and the clinical managers.</p> <p>Specialised training and related competencies are in place for the clinical staff.</p> <p>Residents and families interviewed expressed a high level of satisfaction with the care delivered.</p> <p>The general practitioner reported a high standard of care provided at the service.</p> <p>Consultation is available through the organisation's management team at head office that includes registered nurses, regional manager, clinical and quality manager, dietitian etc. A physiotherapist is available during the week.</p> <p>Work has been completed to improve the staffing levels, quality and risk management programme and culture of the service.</p> <p>The key projects implemented in the past year included the following: a)</p>

		<p>response to resident feedback around food services; b) refurbishment of the facility including making three of the four-bed rooms into two-bed rooms; c) improvements in the quality programme including completion of a log with 'traffic light' colours indicating whether projects are on track, at risk or completed; d) review of the roster to look at staffing levels, use of bureau (significantly reduced in 2015) and alignment of staff start and finish times with resident needs; e) review of training with all staff now having completed core training, optional training and training relevant to their roles.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guided staff on the process to ensure full and frank open disclosure was available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in 25 completed accident/incident forms.</p> <p>Family contact is recorded in residents' files.</p> <p>Interviews with family members confirmed they are kept informed. Family also confirmed that they are invited to the care planning meetings for their family member and could attend the resident meetings. A family meeting is now being held six monthly with the first one held in 2015.</p> <p>Interpreter services are available from the district health board. There are no residents requiring interpreting services.</p> <p>The information pack is available in large print and this could be read to residents.</p> <p>Staff had training around communication in 2014 and 2015.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. All were signed on the day of admission.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service provides rest home and hospital level of care under the aged care contract. The service is able to provide support for a maximum of 87 residents with 40 beds identified as rest home only and all others as swing beds. There is an occupancy of 75 on the day of the audit (36 residents requiring rest home level of care and 39 requiring hospital level of care).</p> <p>Melrose is part of the Oceania group with the executive management team including the chief executive, general manager, regional manager, operations manager and clinical and quality manager providing support to the service.</p> <p>Communication between the service and managers takes place on at least a monthly basis.</p> <p>Oceania has a clear mission, values and goals. These were communicated to residents, staff and family through posters on the wall, information in booklets and in staff training provided annually.</p> <p>The business and care manager (BCM) is an experienced health manager and has been in this position since August 2013. The BCM also manages Elmswood which is another Oceania facility in Tauranga across the road from Melrose. The BCM, who is not a registered nurse, is supported in their role by a clinical manager. The clinical manager is from Elmswood and is acting in the role while the current clinical manager is on leave. The clinical manager and BCM are also supported by an Oceania clinical and quality manager as well as a regional operations manager from Oceania. The BCM and clinical manager personnel files indicate that both have attended education relevant to their roles.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>There is a clinical manager (registered nurse) who is the second in charge with the clinical and quality manager (registered nurse) and the regional operations manager providing support and oversight in the absence of the business and care manager. The BCM reports that the clinical manager has extensive experience in aged care and they are confident in their ability to perform the BCM role during temporary absences. Their annual practicing certificate was sighted.</p>

<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Melrose uses the Oceania quality and risk management framework that is documented to guide practice. The operations and business brief identified specific areas for development and the plan was documented and reported on through the business and care manager's business status reports to the executive team.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to say that they have read and understood.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed. There is documentation that includes collection, collation, and identification of trends and analysis of data.</p> <p>Meeting minutes evidence communication with all staff around all aspects of quality improvement and risk management. There are also monthly resident meetings that keep residents informed of any changes. Staff report that they are kept informed of quality improvements. Six monthly family meetings have also been initiated. Meetings are attended by staff from both Elmswood and Melrose and this serves to inform practice.</p> <p>There is an annual family and resident satisfaction survey with a high level of satisfaction documented. Corrective action plans are in place for two areas identified as having a lower rate of satisfaction.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or</p>

		risks minimised or isolated. Health and safety is audited monthly.
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>Policy identifies that the organisation requires all incidents, accident and adverse events to be reported immediately. Responsibilities are clearly identified. Actions to be taken are clearly set out in graph form for staff to follow.</p> <p>Management understood their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified. There have been two coroners' reports and an outbreak in 2014 that have required essential notification with this completed in a timely manner. Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required.</p> <p>Incident and accident reporting processes are well documented and any corrective actions to be taken are shown on the forms used by the service. Families are notified of any adverse, unplanned or untoward events at times they have nominated. Family/whānau interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives. Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. Falls management strategies are implemented for residents who have falls.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.</p> <p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles, which</p>

		<p>are repeated annually, as confirmed in staff files.</p> <p>Staff undertake training and education related to their appointed roles. Staff education includes the training programme developed by the aged care consultant. The education programme covers the contractual requirements of the aging process. There is also education, training and clinical mentoring provided through external providers and the DHB specialists. Education records were sighted in the staff files and the training records. The service also has access to specialist aged care online training. Care staff interviewed stated that they valued the education provided with this noted as being relevant to their roles.</p> <p>Residents and families interviewed, along with the resident and relatives satisfaction survey results, identified that residents' needs are met by the service. No negative comments were voiced during interviews on the days of audit.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy identifies staffing levels and skill mix is maintained to meet residents' needs and to comply with the funders contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe and quality care.</p> <p>The business and care manager and clinical manager report that additional staff would be rostered to meet residents' needs and this was confirmed by staff interviewed. Required staffing levels and skill mix is clearly documented to meet contractual requirements.</p> <p>A review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents interviewed stated that all their needs have been met in a timely manner.</p> <p>There is always at least one staff member rostered on to each shift with first aid qualifications.</p> <p>The business and care manager and both clinical managers from Elmswood (sister site opposite to Melrose) and Melrose are on call.</p>

		There are appropriate levels of kitchen, cleaning, activity and maintenance staff.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Information is entered into the resident information management system in an accurate and timely manner. Records are securely stored. Archived records are stored onsite.</p> <p>Progress note entries are made by staff on duty at each shift. The records are legible and the name and designation of the staff member documented on records. All records pertaining to individual residents are integrated. Information of a private or personal nature is maintained in a secure manner and is not publicly accessible.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Entry to service guidelines is clearly documented in service policy, and processes are implemented to ensure residents' entry to the service is facilitated in a competent, equitable, timely and respectful manner. Resident information packs sighted, provided on admission, ensure residents are given sufficient information. Family members interviewed confirm they had received information packs and have been fully informed during all processes.</p> <p>A review of clinical files confirm the necessary needs assessments have been completed and residents placed in an appropriate level of care. Signed and dated admission agreements are sighted and staff interview verifies the processes which ensure residents receive the necessary prescribed care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy and procedures, and the RN confirmed the correct processes are followed around exit and discharge. Referral information provided to other service providers were sighted on clinical files and copies of correspondence retained.</p> <p>One file sampled confirmed a resident who has required a higher level of care has been referred to the needs assessment service co-ordinator (NASC) for a re-assessment. This has been done in a timely manner</p>

		and the resident now receives the appropriate level of care.
<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>	FA	<p>There are documented policies and procedures for medication management. Staff were observed administering medications during the lunch time medication round and follow correct procedures. Administration records are maintained. Interviews with staff and a review of staff files confirmed that only staff who have been assessed as competent are responsible for medication management. Medication trolleys and cupboards are observed to be locked, with the keys being held by the staff member responsible for medications on the day.</p> <p>Medicines have been prescribed by the GP using a pharmacy generated medication chart. All charts include photo identification and any allergies identified. Three monthly GP reviews were evident. Individually prescribed medications are used and a robotics pack system utilised.</p> <p>Controlled drug logs are maintained with evidence of regular reconciliation sighted.</p> <p>One medication file sampled included a resident who self-administers medication. The residents has been assessed as competent to self-administer medications and the relevant form confirming this was signed by both the resident, the RN and the GP. A medication fridge was observed and daily monitoring of temperature completed.</p> <p>There have been no adverse events related to medication management.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Residents are provided with a well-balanced diet which meets nutritional requirements. Kitchen staff confirmed that there is dietitian input into the menu and the relevant report confirming this was sighted. A four weekly menu is followed and the meals provided on the day were in line with the menu sighted. Residents interviewed were satisfied with the meals provided.</p> <p>Dietary assessments were completed on admission and special dietary requirements are highlighted and recorded on whiteboards in the kitchen. Individual food preference lists were sighted and any allergies</p>

		<p>identified. Special equipment is available as required.</p> <p>Kitchen staff have required food safety qualifications.</p> <p>The kitchen was well stocked, clean and tidy. Fresh fruit and vegetables and other food stuffs were stored appropriately.</p> <p>There was evidence of temperature monitoring and maintenance of a cleaning schedule.</p> <p>Labels and dates are on all containers, and food in the chiller is covered and dated. There have been no reported incidents of residents becoming unwell as a result of poor food handling practices.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>Organisational policies provide guidelines around declining entry to the service. There is no evidence of potential residents being declined entry. Clinical staff interviewed are able to give reasons for declining entry and the general practitioner (GP) confirms residents referred to the service have not been declined</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>All residents have a nursing assessment completed. They are completed within the identified timeframes and include resident centred goals. All residents have received a medical assessment on admission, however not all assessments were completed within the required timeframe, and an improvement is required.</p> <p>Residents and families interviewed confirm their involvement in the assessment process.</p> <p>Clinical staff demonstrate use of a variety of assessment tools to assist in the assessment process.</p> <p>Progress notes and interviews with clinical staff confirm that assessment is an ongoing process with regular evaluations being completed by the registered nurse (RN).</p>
Standard 1.3.5: Planning	FA	<p>Long-term and short-term care plans are developed and include goals</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>identified by the resident.</p> <p>Clinical staff interviewed confirm access to resident files and completion of daily progress notes demonstrate prescribed care is completed.</p> <p>There is evidence of allied health support within the care plan process, for example, physiotherapy.</p> <p>Residents observed have the necessary prescribed equipment to minimise risk and promote independence. The GP describes an effective working relationship with staff, and confirms continuity of service delivery.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The Registered Nurse (RN), general practitioner (GP) and care staff were interviewed regarding prescribed care and care plans were sighted. Interventions were consistent with best practice. Short term care plans are developed as required, for example, for one resident who recently developed an infection.</p> <p>Documentation completed daily by care staff confirmed care is being completed as prescribed.</p> <p>Observation of clinical staff handover demonstrated that staff discuss the needs of individual residents on a daily basis. The GP has confidence that interventions are implemented in an appropriate and timely manner.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities team leader and activities co-ordinator were interviewed. Activities are facilitated five days per week. Activities are planned one month in advance and include a variety of activities appropriate to resident needs.</p> <p>Support is provided for individuals to attend activities specific to their needs, and includes transport and one to one support. Residents were observed participating in the days planned activity, they are well supported and appear to be enjoying the activity.</p> <p>Participation records were maintained and residents confirm participation is voluntary and they were satisfied with the activity</p>

		programme. Activities boards were visible in common areas and each resident is provided with a monthly activities plan. Photos of previous events are displayed in common areas and in albums.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>A policy describes an evaluation process. Files sampled included evaluations which are documented according to policy, they are conducted regularly and describe the degree of achievement and progress towards meeting desired outcomes. The RN described the process, and evaluations sighted showed clear links to the care plan.</p> <p>The RN initiates changes to the plan of care where progress is different from expected, for example, short term wound care plans.</p> <p>Family members confirmed a high level of satisfaction with the service supporting the resident to achieve their desired outcome.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Interviews with clinical staff, GP and family members confirmed that residents are provided with access to other service providers as required.</p> <p>Files demonstrate links via a referral process with external health professionals, for example, acute care hospital and speech therapy. Care plans have been adapted as necessary to include specialist care and advice. Families stated they have been kept fully informed during the referral process.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances were in place and incidents were reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and accessible for staff.</p> <p>Chemicals are stored securely.</p> <p>Personal protective equipment/clothing (PPE) sighted includes</p>

		<p>disposable gloves, aprons and goggles.</p> <p>Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons appropriately.</p> <p>The cleaner demonstrated knowledge of handling waste and chemicals.</p> <p>The hazard register is current. Staff received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</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>	<p>FA</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires in November 2015.</p> <p>Maintenance is undertaken by maintenance staff as required. Electrical safety testing occurs annually and all electrical equipment sighted had an approved testing tag. Clinical equipment is tested and calibrated by an approved provider at least annually.</p> <p>The building is an older one that requires frequent painting and maintenance. A planned maintenance schedule is in place and indicates that the service is managing and addressing issues before they arise.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. Regular environmental audits sighted identify that the service actively strives to maintain a safe environment for staff and residents.</p> <p>The service identifies planned annual maintenance and hazard identification forms for areas that require maintenance. There are external areas off the lounge and dining areas. Outdoor areas have shade. There is access to garden areas.</p> <p>Residents and family members confirmed the environment is suitable to meet their needs. All interviewed praised the refurbishment programme that has seen changes in the reconfiguration of rooms that had four</p>

		beds in them to two beds in a bedroom now with a partial wall for privacy (refer 1.1.3).
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible toilets/bathing facilities located in each wing. Visitor's toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members interviewed report that there are sufficient toilets and showers.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner.</p> <p>Residents interviewed all spoke positively about their rooms. Equipment was sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff and the resident.</p> <p>Rooms could be personalized with furnishings, photos and other personal adornments and the service encouraged residents to make the room their own.</p> <p>There was room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.</p> <p>The service has refurbished three bedrooms that had four beds initially into three rooms that now have two beds in them. This has allowed residents using these rooms to have greater privacy and space of their own (refer 1.1.3).</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p>	FA	<p>The service has lounge/dining areas including areas that could be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>Residents can choose to have their meals in their room.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The service has standing operating procedures in place for cleaning. There is a dedicated secure storage area for cleaning equipment and chemicals. Products purchased from an external company are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.</p> <p>All laundry, including residents' personal laundry, is completed on site. During interview, residents and family state that at times the laundry is an issue and the service is aware of this and is actively working on resolving issues raised. Staff interviewed confirm they always have enough linen to meet day-to-day needs.</p> <p>There is a dirty area in the laundry to place the laundry bags and a separate clean area for clothes and linen.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked monthly and annually by an approved provider.</p> <p>Emergency supplies and equipment include food and water. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking.</p> <p>The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved fire evacuation plan. A letter sighted from the New Zealand Fire Service confirmed the approved evacuation scheme. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service. The</p>

		<p>business and care manager attends regional emergency planning.</p> <p>Emergency education and training for staff includes six monthly trial evacuations.</p> <p>Appropriate security systems are in place. Staff and residents interviewed confirmed they feel safe at all times.</p> <p>Call bells are located in all resident areas. Resident and family/whānau interviews confirm call bells are answered in an acceptable timeframe. The service has addressed issues around the 'old' call bell system and there are plans to replace this in the next financial year. Call bells were randomly checked on the day of the audit and all were displayed and answered in a timely manner.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.</p> <p>Family and residents interviewed confirmed the facilities are maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The clinical nurse manager (CNM) is the designated infection control co-ordinator. The co-ordinator confirmed that a surveillance programme is maintained.</p> <p>Surveillance data sighted included infection details related to clinical files sampled.</p> <p>Monthly analysis and an annual review of the infection control programme was completed. Reports are provided at monthly general staff meetings with minutes sighted.</p> <p>Interview with the GP, review of clinical files and medication charts showed antibiotics are prescribed only if clinically indicated.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>Staff observed during the audit completed hand hygiene and use personal protective equipment appropriately.</p> <p>An emergency kit, for use in the event of an outbreak was sighted and is accessible and appropriately stocked. A storage room also contains extra supplies of personal protective equipment (PPE), hand sanitizer and cleaning equipment.</p> <p>Hand sanitizer is readily available to residents, staff and visitors. Staff are able to identify infection control team personnel.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>Policies and procedures are available and the co-ordinator was able to demonstrate that available external resources are utilised to ensure current best practice. During a recent outbreak, staff followed District Health Board outbreak notification guidelines. Documentation was sighted that confirmed this.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Education has been provided to staff around infection control and is also included in the orientation process. Training sessions were documented and attendance records completed. Minutes of general staff meetings sighted included discussions related to infection control practices.</p> <p>The infection control coordinator has received training and demonstrates access to external resources relevant to this role.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection control co-ordinator confirmed a surveillance programme is maintained. Surveillance data was sighted and included infection details related to files sampled. Monthly analysis was completed and reported at monthly general staff meetings.</p> <p>The infection control surveillance is appropriate to the size of the service.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraints and enablers are used appropriately. Care plans included alternative interventions to restraint. Monitoring was completed when restraint and enablers were in use. Staff have been provided with education related to the safe management of restraint and managing behaviours of concern, and staff identified that enablers are required to be voluntary and the least restrictive option.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	<p>FA</p>	<p>A restraint committee that meets at least three monthly (minutes sighted). The restraint coordinator and restraint committee have approved all restraint use, in conjunction with the GP and nursing team. Consent from family/whanau, GP and RN is required before restraint is approved. Consent forms are sighted in resident's files that have a form of restraint in use.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The service has a restraint assessment form that includes the factors of this standard. The restraint coordinator reports that restraint is only put in place following appropriate review of the risks and benefits of restraint or enabler use. Residents with restraint in use have documented assessments for challenging behaviours.</p> <p>The clinical staff demonstrated an understanding of implementing alternatives to restraint, such as low beds, whenever possible.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Interview with the restraint coordinator confirmed that restraint is only applied after consideration is given to all possible alternatives. Restraint is monitored according to risk and a restraint register is maintained.</p> <p>Restraint use is documented in the restraint register (sighted). The restraint register records the type of restraint, when approved, review dates and if the restraint is still recommended for user. All restraints are recorded in the register and consented to by the family/whanau and the resident as appropriate.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint coordinator reported that all restraint and enabler use is evaluated at least three monthly as part of the resident review process. The evaluation process is sighted in the files of residents with restraint use. Restraint reviews are reported and discussed at the restraint committee meetings. The resident and family/whanau consultation is included in the evaluation of both the residents with restraint use.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The monitoring form includes the type of restraint, reason for use, time frames for monitoring, how long the restraint is to remain in use and a record of the checking of the resident. The file review of one resident's monitoring form indicates two hourly monitoring of the resident. The progress notes record that the resident had two hourly checks overnight.</p> <p>The quality review of restraint is part of the three monthly restraint committee meeting and includes evaluation of all aspects of restraint implementation, if education of staff is required and any corrective actions required.</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 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	PA Low	Bedrooms are either single, two-bed or four-bed occupancy. The service has completed the refurbishment of some four-bed rooms into two bedrooms with curtains able to be pulled so that residents cannot be seen from the hallway.	The curtains do not separate the two-resident bedrooms entirely (there is a small gap between the wall separating the beds and the curtain that closes the beds off from the hallway/doors).	<p>Ensure that there is privacy when cares are being provided and as the resident chooses.</p> <p>180 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	Six of nine clinical files provided evidence that a medical assessment had been completed within 48 hours of admission.	Three of nine residents had not had a medical assessment completed within 48 hours of admission	<p>Ensure residents have a medical assessment completed within 48 hours of admission.</p> <p>180 days</p>

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

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

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

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

No data to display
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End of the report.