# Henrikwest Management Limited - Craigweil House

## Introduction

This report records the results of a Provisional 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 HealthShare 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:** Henrikwest Management Limited

**Premises audited:** Craigweil House

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

**Dates of audit:** Start date: 3 July 2017 End date: 4 July 2017

**Proposed changes to current services (if any):** Henrickwest Management Limited intends to take ownership of Craigweil House ten days after confirmation by HealthCERT.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 51

# 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.

## General overview of the audit

Craigweil House can provide care for up to 68 residents requiring rest home, hospital or dementia care. This provisional audit was conducted against the Health and Disability Service Standards and the service contract with the district health board (DHB) to assess the service provider’s current level of compliance and the potential new owner’s preparedness to take ownership.

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. The potential owners were interviewed and they are familiar with their obligations to the Health and Disability Sector Standards with current ownership of other aged care facilities. There are no changes anticipated if ownership is approved.

The potential owners have completed the requirements for owning a new rest home and were well prepared. The potential owners already own other rest homes and have a management team in place that includes the managing director, general manager and clinical managers. There are no intentions to change existing services or the environment should the sale of the service be confirmed.

Two low risk improvements were identified. These include the manner in which trends are identified and the installation of a call bell system in two toilets.

## Consumer rights

Residents receive services in line with the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code). The systems protect their privacy and promote their independence. There is a documented Maori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents’ values and beliefs.

Management and staff communicate in an open manner and residents and relatives are kept up-to-date when changes occur. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

The rights of residents or their legal representatives to make a consumer complaint is understood, respected and upheld. An up-to-date complaints register is maintained. Consents are documented by residents.

The potential owners are familiar with the Code and could describe implementation for residents.

## Organisational management

There is an annual business plan in place which defines the scope, direction and objectives of the service and the monitoring and reporting processes. The service is managed by the facility manager who is a registered nurse with a current practising certificate.

There is an established quality and risk management system in place. There are a range of policies, procedures and forms in use to guide practice. Quality outcomes data is collected. An internal audit schedule is in place. Adverse events are reported to management and external agencies. The potential owners use the same quality systems and policies developed by an external consultant in other facilities and there is no intention to change any part of the quality and risk management programme.

The human resource management system is consistent with accepted practice. There is an annual training plan in place that includes mandatory training. There is a clearly documented rationale for determining staff levels and staff mix in order to provide safe service delivery in the rest home, hospital and the dementia unit. An appropriate number of skilled and experienced staff are allocated to each shift.

Resident information is stored securely.

## Continuum of service delivery

Registered nurses are responsible for the development of care plans with input from the residents, staff and family/whanau representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and DHB requirements.

Planned activities are appropriate to the residents assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

A medicines management system is in place and medicines are administered by staff with current medication competencies. All medicine charts are reviewed by the general practitioner (GP) every three months or whenever necessary according to policy.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

## Safe and appropriate environment

All building and plant complies with legislation with a current building warrant of fitness and New Zealand Fire Service evacuation scheme in place. A preventative and reactive maintenance programme includes equipment and electrical checks. 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. There is a dementia unit that has specifically identified indoor and outdoor areas for residents. Outdoor areas are available for residents in the rest home and hospital units.

Essential emergency and security systems are in place with regular emergency drills and staff training completed.

## Restraint minimisation and safe practice

There is a designated restraint coordinator and restraint committee. The use of restraint is minimised and there were four residents using restraint. Enablers are used on a voluntary basis if needed. All restraint and enabler use is assessed, approved and monitored. Staff receive ongoing sufficient education and maintain their competencies. Policies and procedures on restraint and enabler use are current. Residents in dementia unit are kept in a safe and secure place as there is environmental restraint in place in form locked coded doors.

## Infection prevention and control

The infection control management systems minimises the risk of infection to residents, visitors and service providers. The infection control coordinators are responsible for co-ordinating education and training for staff. Infection control education is provided to staff. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

## 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 | 48 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 1 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Policies and procedures are in place to ensure resident rights are respected by staff. Staff receive education during orientation and ongoing training on consumer rights is included in the staff annual training schedule. In interview, staff were all able to articulate knowledge of the Health and Disability Commissioner’s Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. Visual observations during the audit and the review of clinical records and other documentation indicate that staff are respectful of residents and incorporate the principals of the Code into their practice.  The service provides information on the Code to families and residents on admission. Residents and family interviewed state that they believe receive services as per the Code.  The potential owners were interviewed and confirm knowledge of the Code and advocacy services. Examples were given of application of the Code into their current businesses. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. Staff mostly use verbal consents as part of daily service provision. Staff demonstrate an understanding of informed consent processes.  Residents and relatives confirmed that consent issues are discussed with the relatives and residents on admission. Appropriate forms are shown to them at this time and thereafter as relevant. All residents' files reviewed include documented written consent.  All residents have the choice to make an advanced directive. In records reviewed, all competent residents have an advanced directive. These are signed by the resident. The GP has made a decision for some residents as not for resuscitation with this noted as being a clinical medical decision. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families. Information on advocacy services is available at the entrance to the service. Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.  Discussions with family and residents identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files include information on resident’s family and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | There are no set visiting hours and family reported that they are encouraged to visit at any time. Residents confirmed that they are supported and encouraged to access community services or as part of the planned activities programme. Residents continue to be as independent as possible with activities in the community.  Some residents interviewed described walking, visiting the library and shopping as activities they continue to do by themselves. The service encourages the community to be a part of the residents’ lives in the service with visits from entertainers. There are also at least weekly outings for residents in the van to areas of interest.  The potential owners interviewed described encouraging family to be a part of the service. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Policy and procedures are in line with Right 10 of the Code and 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.  Complaints management is explained as part of the admission process with the policy and forms included in the information pack given to potential residents and family. Residents and family confirmed that the management open door policy makes it easy to discuss concerns at any time. Training on the complaints policy and process is part of the staff orientation programme and ongoing education.  The complaints register records the complaint, dates and actions taken. One complaint sampled indicates that timeframes are met as per the policy. There were no outstanding complaints at the time of the audit and the facility manager confirmed that there have been no complaints to external authorities since the last audit.  The potential owners interviewed confirmed knowledge of the complaints process. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Information on the Code and the Nationwide Health and Disability Advocacy Service is displayed in the facility including pamphlets available for residents and family in the dementia unit and hospital. Information around advocacy services and the Code is included in the admission information pack and described by the facility manager as being discussed with residents and relatives on admission.  Residents and relatives interviewed confirm that the Code, the advocacy service and residents’ rights are explained on admission. They also state that they can discuss any concerns with the managers at any time. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are a range of policies and procedures in place to ensure residents are treated with respect. Staff endeavour to maximise residents’ independence by encouraging residents to actively engage in cares and to continue to access the community as long as possible. There is respect for residents' spiritual, cultural and other personal needs as confirmed by residents and family interviewed. Residents are referred to by their preferred name as observed on the day of audit.  Policies and procedures on abuse and neglect are explained by staff with a description of how they would escalate any concerns if these were suspected. Staff and the general practitioner (GP) interviewed confirmed that there was no evidence of abuse or neglect.  Residents and relatives interviewed state that staff have regard for the dignity, privacy, and independence of residents. There are quiet, low stimulus areas that provide privacy for residents in the dementia unit.  The potential owners described what processes they have in place in their other services to support residents and family’s respect and dignity. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff in care provision for Maori residents. The documentation is referenced to the Treaty of Waitangi and includes guidelines on partnership, protection and participation.  Staff interviewed confirmed an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training.  On the days of audit there were no residents who identified as Māori however staff interviewed described how they had asked residents and family who had identified as Māori, about the care they should and could provide for the resident. This includes speaking in Te Reo for residents who identify with this as their language of choice.  Access to Māori support and advocacy services are available if required. Systems are in place to allow for review processes including input from family/whanau as appropriate, for residents who identify as Māori. Links have been made with the Māori community including local marae and Te Ha Oranga Ngati Whatua. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan. Staff interviewed confirmed their understanding of cultural safety in relation to care. Residents and family members interviewed confirmed that values and beliefs are respected by staff.  One resident does not have English as their first language and staff described using family to help interpret for the resident. The staff emphasised a focus on using signs and body language as the resident was now non-verbal. Staff also described using simple language and giving simple choices for residents who have dementia or who find communication difficult. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions.  Staff interviewed demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives reported that staff maintain appropriate professional boundaries, including the boundaries of the health care assistant role and responsibilities. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | There are policies and procedures to guide practice. These align with the Health and Disability Services Standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by an external consultant. Evidence based guidelines, treatment protocols, reference material and resources are available and utilised by staff. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice.  The education programme includes mandatory training requirements for staff and other significant clinical aspects of care delivery. Demonstrated competencies are recorded. Staff interviewed confirmed that the facility provides a learning and supportive environment.  Consultation and advice is also available from health professionals and specialists in the region and staff are able to describe how and when they can make contact. A review of resident files confirmed that staff contact specialists and the general practitioners (GP’s) when required. The GP interviewed confirmed that staff escalate issues in a timely manner when identified.  Family members interviewed confirm they are very happy and satisfied with the care provided to their relatives and expressed a high level of satisfaction with the care delivered.  The potential owners described good practice with examples given of oversight of each facility they currently own. This includes monitoring of indicators and completion of key tasks; a hands-on approach to management and a management team who can provide support to other facilities if required. The directors are members of the New Zealand Aged Care Association and CANZ with conferences attended. Training records sighted for the potential owners confirmed that they have attended training in 2016 and 2017 related to clinical aspects of care and all other components of the Health and Disability standards. They contribute to the Waitemata District Health Board Residential Aged Care Integrated Programme. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There are policies covering communication, access to interpreters and management has an open-door policy. Information is provided in a manner that the resident can understand. Relatives and residents can discuss issues at any time with staff. Resident meetings are conducted. The incident and accident forms include an area to document if the relatives have been contacted. Open disclosure is practised and documented when family are contacted.  Residents and relatives interviewed confirmed that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirmed that they are advised if there is a change in their family member's health status. The GP interviewed reported satisfaction with communication from staff.  There is a policy around use of interpreters and access to interpreting services is documented. Staff can describe how they would access interpreting services if required. They also state that family are encouraged to interpret for their family member. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation is currently privately owned and governed by a board of directors. The managers provide a weekly report to the directors with details of occupancy, risks and ongoing service delivery. Organisational performance is closely monitored by the board through six weekly executive meetings. The facility manager is in telephone contact with the managing director. The board reviews the performance of the facility manager annually.  The business has agreements in place with Waitemata District Health Board (WDHB) for the provision of aged residential care, the provision of Long Term Supports-Chronic Health Conditions, and an agreement with the Ministry of Health for Residential Non-Aged care. There were no residents on the days of audit admitted under the Ministry of Health Agreement.  Of the 68 beds identified as being certified, 28 are identified as dual-purpose beds; 20 as being rest home beds only and 20 identified as being for residents with dementia requiring a secure unit. On the days of the audit, there were 51 residents including 21 requiring rest home level of care; 21 requiring hospital level of care and 9 requiring dementia level of care.  The purpose, values, priorities and goals are documented in the annual business plan for 2016-2017. These goals are then included in the quality and risk management programme. The goals are reviewed annually.  The facility manager is responsible for ensuring services are planned, coordinated and appropriate to meet the needs of the residents. The facility manager is a registered nurse with a current practising certificate and has been in the current role since May 2015. Prior to this they were employed by the facility as the clinical nurse manager and prior to that as a registered nurse with a long history of working in aged care.  The facility manager is supported by the clinical manager who is a registered nurse with a current practising certificate. The clinical manager is employed full-time and has been in the role since September 2015 following an internal promotion. The clinical manager is an experienced registered nurse who has worked extensively in the aged care sector in rest home, dementia and hospital level care.  Both the facility manager and the clinical manager have competed at least eight hours of education in the last year to maintain their practising certificates.  The potential owners state that there are to be no changes to the philosophy of the service until they are well established in their roles if successful in purchasing the facility. The settlement date, should their application be successful, is confirmed as being ten working days following confirmation from the Ministry of Health. The potential owners also confirmed that there would be no changes to any aspect of the service until they had reviewed current processes and systems.  The potential owners are a family who established their business under the name of Henrickwest Management Ltd in 2001 with the purchase of the first rest home also in that year. A second rest home was purchased in 2004 and a third in 2011. One owner (managing director) is identified as the manager for one of the rest homes and facility managers are in place for the other homes. The second owner takes a role in maintaining the buildings. The general manager has a bachelor of business studies majoring in management and has four years’ experience in management of rest homes. There is an accounts/business development manager who also has a degree in business. A review of training for the managing director and the general manager confirm that both have attended a significant amount of training in the past three years both in clinical practice and in management related topics. The owners interviewed confirmed that the family team members and other members of the management team are in contact on a daily basis with formal meetings held at least monthly. The intention is to continue with these meetings and to include managers at Craigweil House should the sale be confirmed.  The prospective provider has a transition plan with timelines allowing timeframe for implementation. |
| Standard 1.2.2: Service Management  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. | FA | During the temporary absence of the facility manager, the clinical manager is available and experienced to cover the service. If the facility manager was unable to perform the role for an extended period, then the board would reconsider other options.  The potential owners have a management team of facility managers and clinical managers in other services that they currently own. They state that there would be support from the managers if required but noted that there was not expected to be any change in the system already in place. |
| 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 quality and risk management programme identifies objectives for the service. Activities within the programme are closely linked with health and safety, adverse event reporting, the infection prevention and control programme, restraint minimisation, and the resident complaints process. Quality related data and outcomes are collated, analysed and shared with staff at regular staff meetings. The prospective owners state that they will continue to implement the quality plan.  Policies are reviewed every two years. The service uses an external consultant to provide advice on policies, procedures and forms. Policies sighted reflect current good practice, legislation and compliance requirements. The potential owners use the same external consultant to develop policies and no change to the current manuals are expected.  All documents sampled are controlled and obsolete documents removed from circulation. Policies and procedures and the internal audit schedule include reference to interRAI and care planning processes.  The internal audit schedule is documented annually. Internal audits are planned and corrective actions are documented and implemented where a variance is identified. Corrective actions are discussed at both management and staff meetings and linked to the quality and risk management system. There is documentation of resolution of issues. There is a process implemented to measure achievement against the quality and risk management plan. Clinical review is well documented in scheduled meetings. While meetings are held, there are gaps in meetings of documentation of all quality improvement data. The potential owners described a monitoring system already in place across the rest homes they currently own. They state that this ensures that trends are reviewed and improvements put in place as a result of this. The intention is to implement this at Craigweil if the purchase is successful.  A risk management plan is included in the quality and risk management plan. The risk register is maintained with evidence that any risks identified are proactively recorded on the register. Health and safety requirements are being met, including hazard identification. Health and safety systems have been reviewed since the introduction of the Health and Safety at Work Act 2015. The health and safety representative has attended training on the new legislation on 17 May 2016 and the legislation has been discussed at board level. Staff can describe their roles and responsibilities in terms of reporting any risks including hazards. Training for staff around health and safety was last provided in November 2017.  The prospective provider intends to continue with the quality and risk management programme with added systems put in place to monitor risk. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are being reported including a Section 31 completed for any pressure injuries identified as grade three or above.  The incident forms show evidence of immediate responses, investigations and remedial actions being implemented as required. This includes reporting to family members and informing the GP when incidents occur. Both family and the GP interviewed confirmed that incidents are reported in a timely manner. The sample confirmed that documented incidents and accidents are closed following review by the clinical or facility manager and linked to the quality system. Monthly statistics on all documented adverse events are collated, analysed and reported at nurse meetings, quality meetings and through board report.  The facility manager and clinical manager understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The potential owners are also able to describe obligations in relation to essential notification. They state that the same system for reporting and monitoring of incidents occurs in the facilities they already operate. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There is an established system in place for human resource management. All staff records sampled included an employment agreement and a position description. Staff have criminal vetting prior to appointment and professional qualifications are validated. All staff receive an orientation and participate in ongoing refresher education. A training plan is documented and implemented annually with at least monthly training sessions offered. Performance appraisals are completed for all staff who have been employed for 12 months or more and this ensures that any individual training needs are identified.  There is a registered nurse in charge on each shift. The registered nurses hold current first aid certificates. Three registered nurses are interRAI competent including the facility manager, the clinical manager and another registered nurse. The potential owners interviewed confirmed that their current facilities have interRAI trained staff with an interRAI trained registered nurse floating between services to support documentation. This role would be expected to include Craigweil House if the purchase is successful. Medicines are given by registered nurses and healthcare assistants who have been assessed as competent in the rest home and dementia unit only.  The dementia unit was opened in 2012. One healthcare assistant who is the senior caregiver working in the dementia unit has completed the unit standards for providing care to residents in a dementia unit. Of the 38 health care assistants, there are 11 who are identified as working in the dementia unit. Of the 11, five have completed level four NZQA training; three are currently completing the level three training and the other three staff are new and will be enrolled once their initial three months of employment has been completed. There is always a health care assistant trained in dementia care on duty with both overnight staff having completed the training. The potential owners confirmed that they would continue with the training of staff including training for staff working in dementia care. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The process for determining provider levels and skill mix is defined in policy and takes into account the layout of the facility and levels of care provided. Staff rosters are developed by the clinical manager and the facility manager. Rosters and staff interviewed and observation on the days of audit confirmed there were sufficient numbers of staff in each area to meet minimum requirements as specified in the DHB agreement. Casual staff are available to pick up extra shifts when staff rostered are on leave with a review of rosters confirming that staff are replaced if absent.  There is a staff member on duty with a current first aid certificate on each shift. The facility requires that all registered nurses hold valid first aid certificates and copies are in place on staff files. The clinical manager is on site Monday to Friday and on call for clinical emergencies/concerns.  Staffing is allocated to each area. There are two health care assistants in the rest home on the morning and afternoon shifts and one overnight. This includes one staff on a short shift who is responsible for supporting the other health care assistant at busy times. There are two health care assistants in the dementia unit morning and afternoon and one overnight. Staff state that they can call for assistance at any time with staff in the hospital described as responding promptly. There are five health care assistants is in the morning, three in the afternoon and two overnight in the hospital. At least one registered nurse is on duty 24-hours a day. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Electronic and paper-based clinical records are maintained for each resident. All records are maintained confidentially. The resident records are stored in a locked cupboard in the nurse`s station or stored electronically with appropriate back-up systems in place. The detail is adequate and records information important for ongoing care and support being provided.  A record of past and present residents is maintained electronically. InterRAI assessments are completed by the registered nurses and inform the development of the residents’ plan of care. Progress records are clearly documented by the clinical staff in the paper-based record. The date, time, signatures and designation of those entering into the records is legible. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry to service policy includes all the required aspects on the management of enquiries and entry. Craigweil House’s welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies.  Records sampled confirmed that admission requirements were conducted within the required time frames and were signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Family/whanau and residents interviewed confirmed that they received sufficient information regarding the services to be provided. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident’s records to confirm this. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medicines management system is implemented to ensure that residents receive medicines in a secure and timely manner and medicine charts sampled complied with legislation, protocols and guidelines. Medicines were stored safely and securely in the treatment rooms and locked cupboards. All medicines are stored separately in the respective wings and each wing uses its own stock and as when necessary medicine and standing orders are given according to policy. Medicine reconciliation is conducted by the RNs when the resident is transferred back to the service. The organisation uses pre-packed medicine packets which are checked by RNs on delivery. All medicines are reviewed every three months and as required by the GP. Allergies are clearly indicated and photos are available to assist with identification.  An annual medicine competency is completed for all staff administering medicines and training records were sighted. The RN and the health care assistant were observed administering medicines correctly in the hospital and dementia wings respectively. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted and all medicines are stored appropriately. There were no expired or unwanted medicines. Expired medicines are returned to the pharmacy in a timely manner.  There were two residents who were self-administering their medicines at the time of the audit. These residents were assessed as competent to do so and their medicines were stored in a secure safe place. A self-administration policy and procedure is in place. |
| 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 | Meal services are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes. The resident’s weight is monitored regularly and supplements are provided to residents with identified weight loss issues.  The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring on fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The service provides additional food over a 24- hour period for residents with dementia and others if they require snacks outside of meal times. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The nursing staff and the hospital coordinator reported that all consumers who are declined entry are recorded on the pre-enquiry form and when a resident is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews residents and relatives expressed satisfaction with the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in short term care plans and long-term care plans are sufficient to address the residents assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed and the staff confirmed they have access to enough supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support they are receiving. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The planned activities are meaningful to the residents. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The activities staff reported that they modify activities based on the resident’s response and interests and also according to the capability and cognitive abilities of the residents.  The residents were observed to be participating in meaningful activities on the audit days. Residents in dementia unit have a 24-hour activity plan in place that links with the long term care plan for management of challenging behaviours. Residents were observed to be going offsite with family/friends, with a number of community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident’s long-term care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes. Family/whanau and staff input is sought in all areas of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | There is a documented process for the management of all referrals. The service utilise a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances on an annual basis. The health care assistants demonstrated knowledge of handling waste and chemicals and were observed to keep the cleaning trolleys in sight when in use. Cleaners in the dementia unit were particularly vigilant around keeping chemicals safe and in sight when in use at all times.  Chemicals are stored securely and the required personal protective equipment/clothing (PPE) is available. Staff confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons when these were required.  Waste is mostly of a domestic-type and is managed via a recycling programme or by local council contracted services. Medical hazardous waste is collected by an external contractor. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current warrant of fitness which is due to expire 8 February 2018. There is a certificate of completion to the existing fire alarm system (issued 10 December 2015) from Fire Protection Inspection Services Limited.  The rest home and hospital are connected under one roof with the dementia unit having a separate roof line. The dementia unit connected to the hospital unit by a covered walkway. The hospital and dementia units are purpose built units with the rest home being an older building. Planned and reactive maintenance is implemented by the maintenance person and contractors.  The physical environment internally and externally is maintained to minimise risk of harm, promote safe mobility, aid independence and is appropriate to the needs of the current residents. Perimeter fencing and securing of the dementia unit has been further strengthened since the last audit. The electrical equipment is checked and records maintained. Testing and calibration of medication devices occurs annually.  The service has two vans used for transporting residents. There is a system for managing the vehicle warrant of finesses and current registrations. There are outdoor areas available for all residents including verandas and outdoor garden areas in the secure dementia unit. ‘  The potential owners interviewed confirmed that there was no intention to change any part of the environment. They did state that they would respond to any maintenance issues in a timely manner as these arose. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are sufficient toilets, hand basins and showering facilities available for residents. The majority of bedrooms have a hand basin, with the exception of two. The rest home has communal toilets with some containing showers. The dementia unit has large shared bathrooms with toilets and showers. The hospital includes some bedrooms with an ensuite. There are appropriate privacy protections in place when showers and toilets are in use with these observed to be used on the days of audit. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents have their own room except for three rooms in the rest home room which are double rooms that are able to accommodate couples. Couples are each able to have privacy in their room if required.  The hospital rooms have double doorways for beds and easy hoist access if required. There is ample room for mobility aides to be used safely in each resident’s room. Residents confirm that there is sufficient space in each room for personal items. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are large lounges in all units including the dementia unit. There are smaller rooms available throughout the building with comfortable seating for family/visitors and group meetings. The lounges are also used for activities. Each area has a dedicated dining room area. There is a sunny enclosed sunroom in the rest home adjoining the rest home lounge that is very popular and well utilised by residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are separate laundry and linen service manuals available containing all relevant cleaning and laundry policies and procedures to guide staff. Staff know how to access the information and can describe implementation as per policy. There are material data sheets available for all chemical products used for cleaning and the laundry. The facility manager monitors the cleaning and laundry service through the internal audit programme to ensure resident and relative satisfaction is maintained. Residents and relatives interviewed confirm satisfaction with the cleaning and laundry services.  The service employs cleaners seven days a week. All cleaning processes are documented clearly for each area of service. There is adequate storage for all chemicals in locked designated areas. There is a cleaning schedule in place with documented daily cleaning tasks to be completed. The maintenance person completes any high cleaning and extra cleaning in the kitchen area as required.  Laundry is performed by dedicated staff seven days a week. There is a large laundry on site that contains commercial grade washing machines and clothes dryer and there is an outside washing line which is used as much as possible. There is dirty and clean separation in the laundry. The laundry staff were able to describe procedures including soaking and washing of soiled and/or infectious linen. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate | There is an approved evacuation plan and this is displayed and current. Emergency drills take place every six months as required. Annual training is also provided on emergencies and security from a health, safety and reporting perspective.  In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare battery lights, a gas barbecue, linen, continence products, torches and batteries, water, gas heaters, and a gas stove. Food dry stock and frozen foods are available.  An electric call bell system is available throughout the three units noting that two bathrooms in the rest home do not have a call bell currently. The call bells in the dementia unit are able to be heard and identified by staff in the hospital.  Security is maintained. The dementia unit is secured with key pad entry. A perimeter fence is erected and is locked with key pads on two gates. Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately. The facility manager, person on call or emergency services can be contacted if staff are concerned or if an emergency occurs. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms have an external window that can be opened for ventilation. The buildings are ventilated by opening windows and doors and extraction systems. Heating is managed by use of heaters in the hallway in the rest home and some residents have individual electric heaters in their rooms which are checked by the electrician and tagged appropriately. The hospital and dementia unit are heated by a built-in heating system. |
| 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. | FA | Craigweil House provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The clinical manager is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.  The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.  There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| Standard 3.3: Policies and procedures  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. | FA | The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff education on infection prevention and control conducted by the ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. |
| 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 clinical manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.  Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.   Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the infection control meeting. When infections were sighted as occurring in files sampled, these were checked in surveillance data. All were recorded and data used to review outcomes both for the individual and the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint minimisation policy. This includes methods for minimising restraint and approved alternatives. Definitions of restraint and enablers are consistent with this standard. Records sampled confirmed that staff actively work to minimise the use of restraint. Goals for minimising the use of restraint are discussed at staff and quality management team meetings.  All staff complete a restraint minimisation competency during orientation. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation and review process.  There are currently four residents who are using a restraint for safety and comfort. These include low beds, bed rails, recliner chairs and lap belts. The assessment, approval, monitoring and review process is the same for both restraints and enablers. Residents in the dementia unit are nursed in a safe and secure place as there is environmental restraint in place in form of locked coded doors. |
| 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. | FA | The restraint coordinator is the clinical manager. The coordinator is supported by the facility manager regarding restraint practice and quality and risk considerations. The role of the coordinator is documented. The use of all restraints and enablers is provided in reports to the staff and quality management team.  The use of restraint must be approved by the restraint coordinator, including the family and GP. The approval process is comprehensive and requires a full assessment of risk and evidence of trialled alternatives. The required approvals were sighted in restraint records sampled. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint assessment process is fully documented and includes the requirements of this standard. Resident records sampled confirmed completed assessments and approvals. Assessments and approvals were signed by the family, the GP and the restraint coordinator. The assessment identified the cause, alternatives, risk, cultural considerations and outcomes. The most common reason for implementing a restraint in the records samples was for safety reasons. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A current updated register was sighted. The long term care plans have documented risk management plans required to ensure the resident’s safety while on restraint. The service has an approval process as part of the restraint minimisation policies and procedures that is applicable to the service and accessible to staff to read. Restraint authorisation is in consultation with resident, family/whanau, restraint co-ordinator and GP. The approval process ensures the environment is appropriate and safe. Restraint use is reviewed at least three monthly and six monthly and as part of restraint register reviews. Staff interviewed demonstrated understanding about restraints and strategies to promote safe practice.The restraint monitoring and observation process is included in the restraint policy. There were no restraint related injuries reported. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Regular reviews are conducted on residents and this was evident in the records sampled.GP confirmed involvement in the restraint review process. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring and any change required. Interviewed staff and family/whanau confirmed involvement in restraint use. The evaluation forms included the effectiveness of the restraint in use and the risk management plans documentation in the long term care plans. Evaluations time frames are determined by the risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service has demonstrated monitoring and quality review on the use of restraint. Restraint updates are included in the monthly staff and periodic quality control meetings. Individual approved restraints are completed three to six monthly through restraint meeting and as part of the facility approval team review with family/whanau involvement. Meeting minutes confirmed discussions on restraint are being conducted and included review of restraint use. The clinical manager reported that assessments and monitoring are appropriate. Policies and procedures are up to date and training record sighted and annual reviews are done. |

# 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 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Low | There are a range of meetings across all disciplines within the organisation. These focus on clinical aspects of care and on aspects of the quality programme however there is an inconsistent approach to ensure improvement of service delivery occurs as a result of the frequency of meetings and ensuring that discussion of all aspects of the quality programme occurs for all staff. Staff are able to describe verbal review of quality data and results in between scheduled meetings. | There are gaps between meetings that do not allow for consistency of discussion of data. | Ensure that meetings are held at a frequency that allows for discussion of aspects of the quality improvement programme.  180 days |
| Criterion 1.4.7.5  An appropriate 'call system' is available to summon assistance when required. | PA Moderate | There are call bells able to be used by staff and others to get help in most areas. Two toilets do not have a call bell. One was a staff toilet and is now used as a toilet for residents and others. One was an ensuite and has since been converted to be a toilet accessible to other residents. | Two toilets do not have call bells or other ways for residents or staff to call for assistance if required. | Ensure that all toilets have a system in place that enables staff, residents or others to call for assistance.  30 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.