

Little Sisters of The Poor Aged Care New Zealand Limited - Sacred Heart

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Little Sisters of The Poor Aged Care New Zealand Limited
Premises audited:	Sacred Heart Home & Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 January 2015 End date: 15 January 2015
Proposed changes to current services (if any):	Click here to enter text
Total beds occupied across all premises included in the audit on the first day of the audit:	58

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Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Sacred Heart Home and Hospital is governed by the Little Sisters of the Poor NZ Trust Board. The board undertakes a mission 'to provide health care services for the elderly, all cultures and all religions'. The service provides rest home and hospital level care for up to 65 residents. On the day of the audit there were 58 residents, 30 at hospital level and 28 at rest home level.

Sacred Heart Home and Hospital is managed by a Mother Superior and a nurse manager. Both receive support from Sisters, administration staff, registered nurses and care staff. The residents and relatives interviewed all spoke positively about the care and support provided.

The service has addressed two of three shortfalls from the previous certification audit around reporting of restraint use via the quality and risk management system and one aspect of medication management. Improvements continue to be required in relation to reporting of pressure injuries via the incident reporting system.

This surveillance audit identified that improvements are required in relation to adhering to timeframes and completing all aspects of care planning as assessed for each resident.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Risk management processes are practised to promote the safety of residents and staff. Sacred Heart Home and Hospital is committed to continuous improvement processes as demonstrated in quality planning including a review of annual objectives, regular internal audits and the collection of data related to the reporting of adverse events. Quality improvement processes are monitored and information is shared with staff. Policies and procedures are followed for the recruitment of staff, including police and referee checks. Performance appraisals are completed annually. Orientation of new staff is comprehensive and addresses all key policy areas. Regular in-service staff training is provided and is well attended. Staffing levels meet contractual requirements.

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 registered nurses are responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whanau. The activity programme is varied and appropriate to the level of abilities of the residents. Medications are appropriately managed, stored, and administered with supporting documentation. Medication training and competencies are completed by all staff responsible for administering medicines. Food is prepared on site by a contracted company with individual food preferences, dislikes and dietary requirements assessed by the registered nurses and a dietitian.

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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The service displays a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

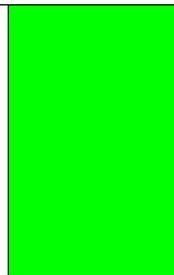


Standards applicable to this service fully attained.

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There are 11 hospital residents requiring an enabler and one hospital resident with restraint.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. The service implements effective outbreak management procedures.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	3	0	0	0
Criteria	0	36	0	3	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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>The service has a complaints policy and procedures in place and residents and their family/whanau are provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained with all documentation which shows that complaints are managed and resolved. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Six residents (three rest home and three hospital) and three hospital family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur six monthly and the mother superior, nurse manager and registered nurses have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau).</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 special character of the Sacred Heart Home and Hospital is central to resident care. The facility is governed by a mission board located in Auckland.</p> <p>A business, quality and risk management plan describes the five key goals of the facility (consumer focus, provision of effective programmes, certification and contractual requirements, risk management and continuous improvements). Each goal describes the objectives, management controls, measurements and allocated responsibility. Goals are monitored annually by the quality improvement team. The Mother Superior oversees the running of the facility with clinical management delegated to a nurse manager. The nurse manager has been in the role for the past six months and is a registered nurse with extensive experience in aged care management. She has completed in excess of eight hours of professional development in the past six months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The quality manual and the business, quality, risk and management planning procedure describe the Sacred Heart Home and Hospital's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the quality improvement meeting, and the various facility meetings. Monthly and annual reviews are completed for all areas of service. Meeting minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirm their involvement in the quality programme. Resident/relative meetings are held. Restraint and enabler use is now reported within the quality improvement and clinical meetings. The service has addressed and monitored this previous shortfall.</p> <p>Data is collected on complaints, accidents, incidents, infection control and restraint use. There is an internal audit schedule which is being implemented. Areas of non-compliance identified at audits are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary</p>

		certifications and documentation is completed in a timely manner. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. .
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	Incident and accident data is collected and analysed. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for November and December 2014 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. Reports were completed and family notified as appropriate. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service includes pressure injuries in incident reporting forms and monthly analysis and has now addressed this aspect of a previous finding. Further improvement is required whereby all pressure injuries are reported.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 25 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Care workers are orientated by 'preceptors'. Annual appraisals are conducted for all staff. There is a completed in-service calendar for 2014 which exceeds eight hours annually. Care workers have completed either the national certificate in care of the elderly or have completed or commenced the Careerforce aged care education programme. The nurse manager and registered nurses attend external training including conferences, seminars and education sessions with the local DHB.

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Sacred Heart home and hospital has a four weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is at least one registered nurse and two care workers on duty at all times. The full time nurse manager is also a registered nurse. Care workers advise that sufficient staff are rostered on for each shift. Staff turnover is low. All registered nurses and senior care workers are trained in first aid. Staff and residents are supported by a group of Sisters who live and work within Sacred Heart.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. The service has addressed and monitored a previous shortfall relating to medication administration practice. A contracted pharmacy supplies packed medications. All medications are managed appropriately in line with required guidelines and legislation. Twelve medication charts sampled met all the prescribing requirements. Each drug chart has a photo identification of the resident and allergies or nil known allergies are recorded on the medication chart. Residents who wish to self-medicate are appropriately assessed and supported to do so. Internal medication audits are conducted six monthly. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.</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>	<p>FA</p>	<p>All meals at Sacred Heart home and hospital are prepared and cooked on site by a contracted company. There are four weekly summer and winter menus with dietitian review and audit of menus. Meals are prepared in a well-appointed kitchen adjacent to the rest home dining room for serving. Food is transported to the hospital residents in hot boxes and served immediately to residents. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. There is food available for residents outside of meal times. Residents who require special eating aids are provided for to promote independence. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurse or nurse manager. A dietitian visits the service every two weeks and reviews residents as required. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by the dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicate satisfaction with the food service.</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>A written record of each resident's progress is documented. Changes are followed up a registered nurse (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and a treatment rooms are well stocked for use. Wound documentation was reviewed and includes wound assessment, treatment plans and evaluations and progress notes. Advised that wound care nurse specialist advice is readily available. Contenance products are available and specialist contenance advice is available as needed. Short term care plans are recorded, however, many of the plans reviewed lacked sufficient detail to guide care staff in the provision of care (link #1.3.8.3). A physiotherapist and physiotherapist assistant are employed to assess and assist resident's mobility and transfer needs.</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 staff at Sacred Heart home and hospital provide an activities programme over five days per week. Group activities are voluntary and developed by the activities staff. Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. Sacred Heart home and hospital has its own van which is used for resident outings. The group activity plans are displayed on notice boards around the facility. All residents who do not participate regularly in the group activities are visited by a member of the activity staff with records kept to ensure all such residents are included. All interactions observed on the day of the audit indicated a friendly relationship between residents and activity staff. The resident files reviewed included a section of the lifestyle care plan was for activity and is reviewed six monthly. Residents interviewed spoke very positively of the activity programme with feedback and suggestions for activities made via meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Initial care plans are evaluated within three weeks of admission. Long term care plans are reviewed and evaluated by the registered nurses or when changes to care occur as sighted in the files reviewed. A multi-disciplinary team meeting is conducted annually for each resident and involves all relevant personnel. Advised that the house GP examines the residents and review the medications three monthly. Short term care plans focus on acute and short term needs, however as evidenced in the sample of files reviewed, lack sufficient detail and not all on-going problems have been recorded in long term care plans.</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>The service displays a current building warrant of fitness which expires on 4 March 2015.</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>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually at facility and organisational level. An infection control team has been established for the purpose of monitoring infection rates, analysis of data and education and information for staff. An outbreak in 2014 was limited to four residents and was appropriately managed. Recommendations from Public Health South have been actioned.</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>Documented systems are in place to ensure the use of restraint is actively minimized. The facility was utilising restraint for one hospital resident (bedrails) and 11 hospital residents have been assessed for enabler use (bedrails) on audit day. Advised that bedrails are used as a falls prevention method and to promote residents safety and security. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The quality improvement team and registered nurses reviews restraint policy, education and audits.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>The service gathers incident and accident data for resident and staff incidents. Resident incident forms were reviewed for November and December 2014. Incident data includes falls, skin tears, bruising, medication errors, behaviours, near misses, and serious harm. The sample of incident reports reviewed where completed with appropriate clinical care conducted following an incident. Staff record the incident in progress notes and the nurse manager reviews all forms for further investigation and sign off. Two residents with a pressure injury had the incident reported via the incident reporting process – one further resident with a pressure injury did not.</p>	<p>One resident with a pressure injury did not have the incident reported via the incident reporting procedures.</p>	<p>Ensure that all adverse events are reported via the incident reporting system.</p> <p>90 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>Six resident files reviewed evidence that an initial assessment and initial care plan were developed for each resident within 24 hours of admission. The registered nurses have been trained in InterRAI and are utilising this assessment tool when reassessing residents. Five of six resident files evidence that reassessments have been completed within six months and four of six files evidence that evaluations of the long term care plan have been conducted within six months. As well as using the InterRAI assessment tool, RN's also use a variety of risk assessments including falls risk, pressure area risk, nutrition (MUST) screening tool, behaviour, pain and continence assessments. Long term care plans are based on the InterRAI assessment and any areas of care identified. Two care plans reviewed did not cover all identified care issues.</p>	<p>a) One resident had assessments reviewed at eight months and care plan evaluation conducted at 10 months; one resident had a long term care plan evaluation conducted at seven months; b) one resident with a history of falls did not have a mobility section completed in the long term care plan; one resident with continence issues and dietary needs did not have this recorded on the long term care plan.</p>	<p>a) Ensure that all aspects of assessments, care planning and evaluations are conducted as per timeframes stated in contracts and b) ensure that each resident care plan includes all interventions required to meet the assessed needs.</p> <p>90 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Low</p>	<p>Short term care plans were evident in the sample of resident files. Plans are recorded for infections, wounds, and changes in health. Two of six plans recorded the type of issue, goals for improvement, interventions, evaluation and resolution. It was noted that two of six plans only recorded the type of issue and what medication was being used for treatment. One resident file evidenced that an on-going problem had been transferred to the long term care plan. One further resident file evidenced that</p>	<p>a) A review of short term care plans evidenced that insufficient details were recorded in the interventions to guide staff in the provision of care for the residents; b) one resident file did not evidence that an on-going problem had been transferred to the long term care plan.</p>	<p>a) Ensure that short term care plans provide sufficient detail in the interventions to guide staff in the provision of care; b) ensure that all on-going care issues are transferred from a short term care plan to the long term care plan.</p> <p>90 days</p>

		a comprehensive short term care plan had been developed and signed off; however, the on-going issues had not been transferred to the long term care plan.		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.