# Blockhouse Bay Healthcare Limited - Blockhouse Bay Home

## Introduction

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

The audit has been conducted by The DAA Group 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:** Blockhouse Bay Healthcare Limited

**Premises audited:** Blockhouse Bay Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 14 June 2016 End date: 15 June 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 27

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Blockhouse Bay Home is one of three aged care facilities owned and operated privately by a husband and wife team. It is able to cater for up to 43 rest home level care residents.

This certification audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family/whānau, one general practitioner, management and staff.

There is one area identified for improvement regarding not all residents’ files containing a current interRAI assessment.

## 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. |

Staff interviewed demonstrated good knowledge and practice of respecting residents` rights in their day to day interactions. The clinical nurse manager is fully informed of the obligations of the Health and Disability Commissioner`s (HDC) Code of Health and Disability Services Consumers` Rights (the Code). Education is provided to all staff at orientation and is ongoing. Advocacy and interpreter services are available if required.

There are three residents who identified as Maori at the service at the time of the audit and two staff who identified as Maori. There are no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written informed consents are obtained as required. Signed informed consent forms were sighted in all residents` records reviewed.

Linkages with family/whanau and the community are promoted and encouraged.

The organisation respects and supports the right of the resident to make a complaint. The service has a complaints register and the information is recorded to meet all the requirements of the standard. There were no outstanding complaints at the time of audit.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The organisation's philosophy, mission and vision statements are identified in the business plan. Planning covers business strategies for all aspects of service delivery to ensure services are delivered in a manner to meet residents’ needs.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident surveys, restraint and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and family/whānau, as appropriate. Corrective action planning was sighted for incident and accident follow up as appropriate.

The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. Residents and family/whānau confirmed during interview that all their needs and wants are met.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

The privacy of residents` information is maintained in a secure manner. Residents` records are legible and meet the New Zealand Health Information Records requirements. Medication management is managed through an electronic system and records were reviewed.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Pre-admission information accurately identifies the service offered. The service agreements are signed and dated appropriately.

Services are provided by suitably qualified and skilled staff to meet the needs of the residents. Timeframes for the development and review of the long term care plans are met. Short term care plans are developed when there are changes in the resident`s needs that are not addressed on the long term plan.

The general practitioners` review all residents at the required timeframes. Referrals to other health and disability services are planned and coordinated, based on the individual needs of the resident.

The activities programme meets the social and recreational needs of the residents. The diversional therapist is experienced and activities are planned and are meaningful to residents. Residents are encouraged to maintain links with the community and the family/whanau.

A safe medication system was observed during the audit. The staff responsible for medication administration have completed medication competencies to perform this role.

The residents` nutritional requirements are met by the service with preferences and special diets being catered for. The staff who prepare meals are experienced. The menu plans have been reviewed and approved by a qualified 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. |

The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substance.

There were documented emergency management response processes which are understood and implemented by staff.

The building had a current building warrant of fitness and an approved fire evacuation plan. There have been no changes to the facility footprint since the previous audit.

The facilities meet residents’ needs and provide furnishings and equipment that is regularly maintained. There is adequate toilet, bathing and hand washing facilities. Lounge and dining areas meet residents' relaxation, activity and dining needs.

The facility heating is electric throughout. Opening doors and windows creates an air floor to keep the facility cool when required. The outdoor areas provide furnishings and shade for residents’ use. Residents and family/whānau were happy with the environment provided.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Policy identifies that enablers are voluntary and the least restrictive option to keep residents safe and to promote independence. The facility is restraint free. Policy identifies that one door does have a keypad lock which constitutes environmental restraint but that all residents and their family/whānau are able to come and go freely. This was confirmed during interview and observed on the days of audit.

## Infection prevention and control

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

The infection prevention and control management system is appropriate for the nature of this service. The programme is reviewed annually and implemented. Infection prevention and control reduces the risk of infections to residents, staff, family/whanau and visitors to the facility. Policies, procedures and guidelines are available to guide staff. Staff are provided with relevant education, as are residents when deemed appropriate.

The clinical nurse manager/infection control co-ordinator collates monthly surveillance data. Where any trends are identified actions are implemented. The infection surveillance results are reported at the staff monthly meetings. Relevant expertise is available and can be sought as required.

## 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 | 44 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 0 | 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 | The Code of Health and Disability Services Consumers` Rights (the Code) is displayed in the two wings of the rest home in full view of residents, caregivers and visitors to the facility. The clinical nurse manager and the diversional therapist interviewed stated that the rights of residents are respected.  Staff receive training on the Code at commencement of employment as part of the orientation process. The care staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice.  The Code is available in English and Maori and other languages for residents with English as a second language. |
| 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 | Systems are in place to ensure residents, and where appropriate their family/whanau are provided with appropriate information to make informed choices and informed decisions. The clinical nurse manager interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and residents confirmed they have been made aware of and understand informed consent processes and that appropriate information had been provided.  Policy identifies that residents and family/whanau are able to make informed choices and that their choices are respected by staff.  A multipurpose informed consent form is used and a copy is retained in each of the resident`s individual records reviewed. Some additional forms sighted included the annual influenza vaccination consent forms, photographs taken and used for the medication and individual resident records for identification purposes. Forms reviewed were signed and dated appropriately. The clinical nurse manager and/or the administrator ensured each resident had a service agreement signed and dated on admission for long term care. Admission agreements were in each resident record reviewed.  The GP interviewed understood the obligations and legislative requirements to ensure competency of residents as required for advance directives and reviews are undertaken six monthly.  The clinical nurse manager interviewed reported that education is provided to staff on the principles and practice of informed consent as part of the Code of Rights. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Policy provides guidance for staff related to resident rights, advocacy and support. All residents receiving care at this facility have appropriate access to independent advice and support, including access to a cultural and /or spiritual advocate as required.  Family interviewed reported they were provided with all relevant information regarding access to advocacy services. The contact details of the Nationwide Health and Disability Advocacy Service is in the resident information pack provided on entry to the service. The contact details are also documented on the reverse of the Consumers` Rights brochure. Staff education is conducted as part of the orientation programme for all new employees and is ongoing. |
| 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 | Family/whanau/representatives are encouraged to visit any time and family/whanau are able to participate in the activities programme if they wish to do so. Outings with family members are encouraged and residents are able to enjoy outings in the community as arranged. Family are invited to join the residents on special event days.  Families interviewed reported that they are kept well informed. The contact record in each individual record reviewed evidences families are contacted by staff if any significant changes occur. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Blockhouse Bay Home implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system. During interview residents, family/whānau and staff reported their understanding of the complaints process. Staff confirmed they document verbalised complaints so all issues are accurately reflected and followed up by the nurse manager.  The service has a complaints register in place which identifies the nature of the complaint, the dates received and the actions taken to address the complaints. Documented complaints information is used to improve services as appropriate. Complaints information is shared at staff meetings and with the owner/director. This is confirmed in meeting minutes sighted and during staff and management interviews.  There were no outstanding complaints at the time of audit and all complaints have been able to be resolved at facility level. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | A copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and the clinical nurse manager goes through the Code with the resident/family/whanau during the admission process.  The family members that were available to interview reported that the Code was explained to them on admission. Interviews with residents who were able to provide insight into their care, expressed they were treated with respect and were happy at the rest home.  An interpreter service is available through the Auckland District Health Board. Contact details are readily accessible to staff if and when required. Staff from different nationalities are available to translate as needed. The clinical nurse manager and caregivers interviewed displayed an understanding of the Code and demonstrated respect to all residents. |
| 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 | Procedures to maintain resident independence, privacy and dignity are documented. There is policy in place which identifies that residents will not be subjected to any form of discrimination, abuse or neglect. The general practitioner interviewed reported that visits are conducted for each resident in their own individual rooms and privacy is respected.  Staff receive training every two years on abuse and neglect.  The residents` records reviewed indicated that residents received appropriate services that were responsive to their needs, values and beliefs of culture, religion and ethnicity.  The families interviewed reported satisfaction with the way the service meets the needs of their relatives.  No concerns were raised in relation to abuse and neglect from residents, the general practitioner (GP), family and/or staff interviewed. |
| 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 | Policy shows how the service respects and acknowledges Maori residents and their family/whanau and their individual, cultural values and beliefs. The Maori Health Plan states that the service recognises the principals of the Treaty of Waitangi and also key principals towards Pacific Peoples Health. Maori and Pacific Island Health Strategy is based upon partnership, participation and protection for all, providing culturally appropriate health and disability services. There are no known barriers that exist for Maori residents to access this service. There are three residents that identify as Maori and two staff that identify as Maori.  Values and beliefs are acknowledged on the long term care plans and initial assessment records reviewed.  The clinical nurse manager and caregivers interviewed demonstrated good understanding of services that would need to be provided for Maori residents to meet identified needs and the importance of whanau. |
| 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 | Policy describes actions to be taken to ensure residents receive culturally safe services regardless of their ethnic, cultural or spiritual values and beliefs. The clinical nurse manager and care staff interviewed have an understanding for promoting health and wellness for all residents.  Staff interviewed reported they received training in cultural awareness and respected all cultural needs in their everyday practices. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policy is in place stating that no form of discrimination, coercion, sexual, financial or other exploitation will be tolerated by the service. The staff records reviewed contained job descriptions and employment agreements that had clear guidelines regarding boundaries. There are clear definitions of types of discrimination in policy sighted and key objectives to be upheld for all residents.  The clinical nurse manager is a registered nurse and has completed the professional boundaries workshop in 2015 which is a requirement for the New Zealand Nursing Council. The family/whanau/residents interviewed reported they are pleased with the care provided. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The clinical nurse manager promotes and encourages best practice with staff. Evidence of this was demonstrated during the audit with medication management using an electronic system. No errors had been reported since this system has been implemented. The availability of the latest resources for wound care management was evident during the audit. The contracted quality consultant interviewed had experience working in the aged care sector and managed the policies and procedures effectively.  The general practitioner interviewed is pleased to have discussions with family/whanau if and when required and to visit residents as needed. The family and residents interviewed reported satisfaction with the services and care provided. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy identifies that information will be shared with the resident and nominated family/whanau in a full and frank manner which reflects the principles of open disclosure. Resident and family have a right to know what has happened to them and to be fully informed. There is a family/representative contact record in each resident’s record reviewed.  The cultural awareness policy documents that residents and families who do not speak English shall be advised of the availability of an interpreter or an advocate at the first point of contact with the service.  The GP interviewed spoke of the staff and the communication and relationship with the GP practice and also the effective communication with the contracted pharmacist.  Families interviewed confirmed they were kept well informed of the residents` health status at all times. Evidence of open disclosure was documented in the residents` records sighted and on the adverse event forms completed by staff. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Blockhouse Bay Home has a business plan in place which is fully reviewed annually and monitored quarterly to measure progress towards meeting set goals. Quarterly and annual reviews were sighted. The plan identifies both strategic and workplace goals which show how services are planned, coordinated and delivered to meet residents’ needs. The organisation’s philosophy, mission statement and values are clearly documented and the owner/director confirms they underpin all planning processes.  On the day of audit the service had 27 rest home level care residents.  The current owner/managers have been involved in the New Zealand aged care industry for over 11 years and have owned Blockhouse Bay Home since 2012. One owner/manager oversees all activities at the facility. They are supported by a management team consisting of a nurse manager who is a registered nurse, a diversional therapist and an administrator/maintenance person. The nurse manager has worked in aged care for over 15 years and has been in the current role since 2012. The diversional therapist has worked at the facility for five years and is an accredited educational assessor for aged care. This is the first management role for the administrator/maintenance person. All the members of the management team maintain education and training related to their roles by attendance at conferences, in-service education, off-site training and via internet education. Accountability and responsibilities are clearly described in the job descriptions sighted. |
| 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 a temporary absence of any of the management team the void is filled by the other members of the team. This occurs with the exception of the registered nurse where the clinical component of the role is undertaken by a registered nurse from one of the other two sister facilities owned by the same husband and wife team. Management interviews confirm this allows minimal disruption to services. The owner/director stated that all roles are covered so that timely and appropriate services are maintained. This was confirmed during staff interviews. |
| 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. | FA | Blockhouse Bay Home has a quality and risk management system which is understood and implemented by service providers. This includes the update of policies and procedures which are managed by an off-site organisation, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection, restraint and complaints management. If an issue or deficit is found a recommendation is written and corrective actions are put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. Strategic and workplace goal achievements are measured by the use of key performance indicators at quarterly quality meetings. It was noted that one internal audit that required follow-up did not show the corrective actions taken. The outcome was checked and corrections had been made but not documented. This was not a systemic issue as all other deficits had documented corrective actions.  During the audit the person who provides and manages policies and procedures and oversees the quality processes visited and was interviewed. They stated that all policies and procedures were updated as required to reflect legislative and good practice requirements. Updated documents were emailed to the facility and the nurse manager then informed staff during monthly meetings as confirmed in minutes sighted. Quality systems documented include quarterly review of all data with an annual review of policy compliance. Quality data is trended against previously collected data and benchmarked against other like organisations. The annual review of all quality planning and data occurred in January 2016.  Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management. Staff verbalised examples of quality improvements made such as the decrease in medication errors owing to the introduction of an electronic medicine management system.  The administrator/maintenance person is the nominated health and safety representative but is yet to attend any formalised training. If an issue of concern arises related to health and safety advise is sought from the trained health and safety representative from a sister facility. Actual and potential risks are identified using the quality and risk planning processes. Newly found hazards are discussed at staff meetings and residents are informed as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard register sighted was up to date. |
| 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 | Adverse event reporting as identified in policy is implemented by the service. The nurse manager confirmed their awareness of the organisation’s requirement related to statutory and or/regulatory reporting obligations including the need to report pressure injuries under section 31 of the Health and Disability Services (Safety) Act 2001.  Staff interviewed stated they report and record all incidents and accidents and that this information along with any corrective actions is shared at staff meetings as confirmed in minutes sighted.  Documentation in six residents’ files and the 2016 incident and accident forms reviewed identified that all issues reported had corrective actions put in place when required.  Family/whānau notification is clearly shown in documentation and confirmed during family/whānau interviews.  Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. For example, data collected from incidents and accidents related to falls are recorded on a falls register and corrective actions are tracked via the use of short term care plans, wound care management forms and outcomes such as the successful implementation of the use of walking frames if required. |
| 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 | Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. This is reflected in the seven staff files reviewed. All roles have job descriptions that describe staff responsibilities. Staff complete an orientation programme with specific competencies for their roles. Documentation in the staff files reviewed confirmed some competencies, such as medication management are repeated annually. Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. Employment processes included reference checking, police vetting and gaining signed employment agreements.  The education calendar sighted for 2016 identifies that staff undertake training and education related to the roles they undertake. Topics covered in annual training and education relate to age care and health care services. Members of the management team also attend workshops and seminars specific to management related topics. Education occurs both on and off site. The nurse manager attends district health board RN education days. Caregivers also attend the annual district health board education day for caregivers.  Resident and family/whānau members interviewed, identified that residents’ needs are met by the service. No negative comments were voiced during interviews on the days of audit. This is also supported in the resident satisfaction survey results sighted for 2016 where all responses gained between 100% and 99% ratings. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy identifies staffing levels and skill mix are maintained to meet residents’ needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified and experienced staff are on duty to provide safe and quality care.  Rosters sighted showed that staff were replaced for sickness and annual leave. This was confirmed during interview with staff and management. Staff reported they had adequate time to complete all required tasks to meet residents’ needs.  Resident and family/whānau members interviewed stated all their needs have been met in a timely manner. There is a registered nurse on duty Monday to Friday and on call at all times. Caregivers confirmed they can contact the on-call RN at any time.  The service has dedicated cleaning staff six days a week. Kitchen staff work seven days a week. The roster shows that the activities are undertaken by the diversional therapist Monday to Friday. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Resident information management is described in policy and this meet legislative requirements.  Personal information is entered in all residents` records reviewed. Records reviewed evidenced entries being documented which are legible with signatures and staff designations included. The records are integrated with divisions labelled accordingly. Residents` records are stored in the nurses` station. The residents’ information is not displayed in public view without consent being obtained.  Medication records were accurately documented, signed and dated and reviews occurred within appropriate timeframes.  The administrator maintains the electronic resident register which has all required information to meet the New Zealand Health Information Code. |
| 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 | Policy and a flow chart identify how the entry to service is facilitated. The administrator interviewed explained the process. There is a resident`s information pack available. There is adequate information about the service provided along with the contact details of the service. The service agreement reviewed is based on the Aged Care Association agreement which is individualised to the service. The residents` agreements are signed and dated and stored separately in the manager`s office. The admission agreement identifies any additional charges that are not covered by the service agreement and the relevant costs of each charge required.  All residents at the facility have been pre-assessed prior to admission as requiring rest home level care. The District Health Board (DHB) Needs Assessor Service Co-ordinators (NASC) or the geriatricians at the DHB ensure the relevant information is made available when a resident is admitted. Residents can be admitted from the DHB Health Services for Older People or from the community. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The clinical nurse manager interviewed stated that any risks identified prior to discharge or transfer are documented. A transfer form is utilised and the DHB `yellow bag’ system. The clinical nurse manager ensures open disclosure between services and family/whanau related to all aspects of service delivery. This includes residents for either discharge and/or transfer to another facility or to the DHB.  If there are any specific requests or concerns that the resident or family want discussed, these are noted on the transfer form. The discharge summary and copy of the care plan is provided and covers all personal cares and needs of the resident and any interventions required. Any identified risks, alerts, concerns are highlighted. If a transfer occurs a copy of the medication record with any known allergies is printed off ‘medi-map’. The resident information record and any advance directives also accompany the resident if they are transferred to hospital. If a resident is to transfer to another facility a full interRAI assessment is required. Family are kept informed throughout the process. |
| 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 medication guidelines were reviewed and are clearly documented to provide accurate information and guidance to staff. The policies were reflective of current safe practice guidelines and references were acknowledged. Procedures complied with legislative requirements. Medication reconciliation processes were clearly described. Pharmacy was involved and this has been reviewed during the audit. Processes for Warfarin monitoring, medication errors, self-administration, disposal of medicines and approved terms are documented.  The medications are blister packed and checked by the clinical nurse manager on delivery from the pharmacy. No controlled drugs are on site. The clinical nurse manager oversees all medication management for the facility.  An electronic medication system was implemented after staff training was provided and is working effectively. No medication errors have occurred or have been recorded since implementation. Senior caregivers responsible for medication administration have completed medication competencies annually. A staff signature list is available. A safe system for medicine management was observed on the day of the audit. Administration of medication is electronically recorded. Allergies/interactions are flagged. The GP interviewed stated that the current system is effective and efficiently managed. All medications are reviewed three monthly or earlier if needed. The medication fridge is temperature monitored. There are no residents that self-administer medication. A policy is in place if required. |
| 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 | The cook interviewed was relieving on the day of the audit for the main cook. The cook was experienced and well informed about food handling and practices to meet legislative requirements. The food safety management education undertaken is appropriate to service delivery. The menu plans are developed and were reviewed in 2015 by a registered dietitian and are appropriate for this care setting. A food satisfaction survey was performed January 2016 and results were used for quality improvement.  Policies, procedures and guidelines are available to guide staff. Referrals are sent by the clinical nurse manager to the dietitian if required to meet the needs of the individual residents. The cook and the owner share the role of ordering food, checking deliveries, storage and managing waste management appropriately. Separate cleaning schedules and temperature monitoring requirements are met. The food in the pantry was clearly labelled. The floor is clear. The kitchen was effectively designed, clean and functional for the size of the facility. |
| 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 clinical nurse manager interviewed reported that the service does not refuse a resident if they have a suitable needs assessment service co-ordinators assessment completed for the level of care required.  In the event that the service cannot safely meet the needs of a resident, the resident, the family/whanau and the NASC service are contacted so that alternative residential care can be arranged. This could be, as an example, in the event of a resident requiring a secure dementia service or hospital level care. The GP and the clinical nurse manager would ensure the appropriate referrals for re-assessment are arranged. The residents’ register is up-dated electronically by the administrator if a resident is discharged to another facility. The clinical nurse manager is the only registered nurse and is aware of the responsibility for completing an interRAI assessment when required. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | No interRAI summaries were evident in the residents` records reviewed (Refer criterion 1.3.3.3). Any additional assessments, as required are completed by the clinical nurse manager, such as risk assessments, pain assessments and cultural assessments and others depending on identified needs for the individual resident.  Results of the assessments are discussed with the resident, staff and families and included in the long term care plan as needs with appropriate interventions in place.  Residents, staff and families interviewed reported appropriate care is provided that meets identified support needs and preferences. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The residents` records reviewed have care plans that address resident`s abilities and needs. The strategies minimising falls risk on assessment and use of techniques that are effective for managing challenging behaviour in the records reviewed were evident. The clinical manager understands the interRAI process and this will be implemented for the reviews which occurred six monthly or more often if required.  The individual care plans and individual activities plans identified resident`s activities, motivational and recreational requirements with documented evidence of how these are managed effectively for each individual resident. The diversional therapist interviewed provided insight on how the activities interventions were developed to meet the needs for residents individually.  The residents` records sighted demonstrated service integration. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Support and care is individualised and focused on achieving desired outcomes/goals set. The clinical nurse manager, diversional therapist (DT) and caregivers interviewed demonstrated appropriate skills and knowledge of the individual needs of all residents. Records reviewed showed evidence of consultation and involvement of the resident and family/whanau as able. The residents and family interviewed reported satisfaction with the care and services provided.  Short term care plans are developed as necessary for any event that is not part of the long term care plan. The clinical nurse manager ensures the GPs are kept well informed of progress.  The service has adequate stocks of wound and continence products to meet the needs of the residents. The care plans reviewed demonstrated interventions that were consistent with the resident`s needs being able to be met. Observations on the day of the audit indicated residents are receiving care that is consistent with meeting their individual assessed needs. The clinical nurse manager is responsible for reviewing all care plans. |
| 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 activities programme ensures resident`s individual motivational, recreational and cultural needs are recognised. The diversional therapist (DT) interviewed is experienced and assesses each resident on admission to this service. The residents are provided with the opportunity to maintain interests, choices and activities in a continuing care environment. The diversional therapist stated that the activities programme is developed and implemented for the home. Group and individual activities are arranged.  The activities programme is planned monthly and displayed. Records are maintained by the DT. The daily programme is displayed in the lounge/dining area. Residents and families can access the information displayed. The DT maintains attendance records. Each resident has their own activities plan which is reviewed six monthly or earlier if changes are made. The DT understands that resident participation is voluntary and this is respected.  Residents are encouraged to maintain links with family/whanau and the community. Family interviewed stated that they were invited to participate in special events and one family member enjoyed helping with craft activities. The service has transport for providing outings into the community. There are three residents who attend activities in the community with other groups of people and enjoy this time. The service has connections with other aged care facilities for sporting (physical activities), movies/games and entertainment.  At the time of the audit residents were visibly enjoying activities. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluation of care and activities plans occur six monthly or earlier if required. Evaluations are focused and indicate the degree of achievement or response to supports and interventions and progress to meeting set goals. If a resident`s needs change or if the resident is not responding to the interventions being delivered then this is discussed with the resident and family/representative. Short term plans are initiated as needed.  The caregivers interviewed demonstrated good knowledge of short term care plans. Progress is also discussed with family.  The families interviewed reported that they are consulted when staff have any concerns or when there are changes to the resident`s condition. This is documented on the contact communication records as evidenced in the records reviewed. |
| 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 | Residents are provided with options if required to access other disability services. There is a GP practice with four GPs contracted to this facility. One of the GPs visits regularly and the after-hours is always covered twenty four hours a day seven days a week. The GP interviewed arranges any referrals to specialists as required. There is a process for transferring residents if and when required. The DHB referral system (‘yellow bag’) is followed through and is a guide for the GP and staff after-hours.  The clinical nurse manager interviewed reported that referral services respond to referrals sent. Records of the processes maintained was confirmed in the individual residents` records reviewed which includes referrals and consultations with eye specialists, pacemaker clinic, geriatricians, mental health services for older people, portable x-ray radiologists, district nursing services, podiatry and dietitian services. The GP interviewed reported that appropriate referrals to other health and disability services are well managed. Copies of referrals were retained in the individual resident`s records reviewed. |
| 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 | Policy describes safe and appropriate storage and disposal of waste substances. In order to protect staff, residents and visitors from harm as a result of exposure to waste products the service implements policy. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff report their understanding of safe disposal processes.  Chemicals are stored securely. Three bottles of decanted chemicals were not clearly labelled on the first day of audit. The service obtained the correct labels on day two of the audit and all chemicals were clearly labelled by the end of the audit. A discussion was held with the director, cleaner and administrator/maintenance person and they acknowledged their understanding of ensuring all decanted chemicals remain clearly labelled. Safety data sheets were sighted for the chemicals in use. There is a chemical products reference chart on the wall in the area where chemicals are stored which indicates the majority of chemicals are non-hazardous.  Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves as required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 24 July 2016. (The new building warrant of fitness has been approved and the facility is awaiting the new certificate).  There is a process in place to identify and manage maintenance. This involves the use of external contractors as required. Electrical safety testing occurs annually and was completed in February 2016 by a registered electrician. Clinical equipment is tested and calibrated by an approved provider at least annually and was last undertaken in May 2016.  The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip and walking areas are kept clear of obstructions.  The service identifies planned annual maintenance in the maintenance plan sighted. Day to day maintenance is undertaken as required.  Outdoor areas have been upgraded and new raised gardens have been put in place. Residents can safely and easily access outdoor areas with seating and shaded areas for their use. As observed on the days of audit many family/whānau who visit choose to use an internal outdoor area to sit and talk.  Interviews with residents and family/whānau members confirmed the environment is suitable to meet their needs. |
| 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 adequate centrally located toilet and shower facilities. Toilets and hand basins are shared between two bedrooms. There are separate staff and visitor toilet facilities. Hot water temperatures sighted show that they remain within safe limits for residential care. |
| 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 bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. They are personalised to meet resident’s wants and needs and have appropriate areas for residents to place personal belongings. There are two bedrooms (in B wing) which can be used for couples if required but at the time of audit all bedrooms are single occupancy.  Resident and family/whānau members interviewed confirmed they are happy with their personal space. One resident requested a lock on their bedroom door as another resident kept entering their room. The corrective action implemented was identified on the incident form sighted. This request had been actioned and the resident carries the key with them and staff have access to a spare key for ease of entry to the bedroom. |
| 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 | Residents are provided with adequate areas to meet their relaxation, activity and dining needs. There are two dining and lounge areas. One lounge/dining area is separated by the use of furnishings and the other areas are separate. The dining furnishing have been replaced in the shared lounge/dining area since the previous audit. Both lounges are used for activities as was observed on the days of audit.  Residents and family/whānau voiced their satisfaction with the environment. |
| 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 | The service has documented procedures in place for cleaning and laundry tasks. The laundry has a clean and dirty entrance. The equipment is regularly maintained. Staff stated they inspect the linen post laundering to ensure it is clean and they understand the need to place the washing machines on correct settings when washing items.  The cleaner has a specific trolley to carry all cleaning item on and they are stored securely when not in use.  During interview, residents and family/whānau confirmed they are very happy with the cleaning and laundry services provided. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plan is reviewed annually as part of the quality process. Emergency fire equipment is checked annually by an approved provider and there is an evacuation plan which was approved by the fire service in June 1994. There have been no changes to the facility footprint since this time. Six monthly fire evacuations are undertaken with the last one occurring in April 2016 and no follow up actions were required.  Emergency supplies and equipment include food and water, a first aid kit, an outbreak box and a civil defence box. The contents are checks annually and no outdated items were sighted. It was suggested at the time of audit that the contents should be checked more frequently. The service will look at undertaking quarterly checks.  Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ and cooking.  The security arrangements involve staff ensuring the doors and windows are locked upon dusk. There is a door with a key pad at the entrance from the reception area into the resident area which is opened by using a switch one side and key pad from the inside. Residents were sighted coming and going freely both days of audit. (See comments in standard 2.1.1). Staff and residents interviewed confirmed they feel safe at all times.  Call bells are located in all resident areas. Resident and family/whānau interviews confirmed call bells were answered in an acceptable timeframe. |
| 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 heating is electric and this keeps the facility warm in winter as confirmed during resident interviews. The facility is ventilated via opening doors and windows. All resident areas have at least one opening window for natural light and ventilation. |
| 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 | The service has a managed environment which minimises the risk of infection to residents, staff and visitors. The infection control programme is led by the clinical nurse manager. The infection prevention and control programme is reviewed annually. The clinical nurse manager uses standardised definitions to identify infections appropriately. Monthly records sighted are maintained. Infection prevention and control is presented at each staff meeting and minutes were available.  The clinical nurse manager fully supported the programme and has a good understanding of the early detection of suspected infections. The job description was sighted for this role. The care givers interviewed reported how they notified the clinical nurse manager of any concerns when caring for the residents. Shift handovers are a forum for reporting infections. There have been no outbreaks since the previous audit. Short term care plans are used, for example, for wound care and other infections. There is an infection record which is maintained by the clinical nurse manager.  A process is identified in policy for the prevention of exposing others to infection. Staff interviewed knew when not to come to work and when to return. Signage is used in the facility as required. Sanitising hand gel is evident throughout the facility and there are adequate hand washing facilities for staff, visitors and residents.  The programme reviewed is appropriate for the size and nature of this aged care setting and services provided. |
| 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 job description reviewed identifies that the clinical nurse manager implements and oversees the infection control programme.  The diagnostic laboratory service sends infection reports on a monthly basis and any positive culture results. A summary of exception reports inclusive of chest infections, colds, skin, wound and urinary tract infections were sighted.  External specialist advice is available from general practitioners who cover the service. The laboratory microbiologist and the infection prevention and control nurse specialists at ADHB can also be contacted as required.  The GP interviewed is well informed of obligations and reporting systems if needed for notifiable infection outbreaks of disease or illness. Guidelines and a pandemic plan are in place should an incident arise. An infection prevention and control box with resources was sighted and is available in the event of an infection outbreak.  The service has minimal infections reported as sighted in the documentation reviewed. |
| 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 | Policies and procedures are in place which reflect current accepted good practice and meet relevant legislative requirements. The infection prevention and control programme has been reviewed. The objectives of the infection prevention and control programme are documented. Infection control policies are available to guide staff.  Specific infection control areas, such as for surveillance, wound-care management, blood and body spills, cleaning and disinfectant are covered adequately. Standard precautions are adhered to throughout all areas of service provision.  Staff demonstrated safe and appropriate infection prevention and control practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection prevention and control education is provided to all staff at orientation and is ongoing. Previously staff covered infection control in the ACE programme and are now changing over to the Careerforce training. Programme. An external contracted education facilitator provides annual updates on infection control and wound care management.  The clinical nurse manager has records of attending the update education provided in May 2016 at ADHB. A certificate and record of attendance was sighted. All education records for staff is maintained by the clinical nurse manager. The organisation is a paid member of an infection prevention and control group which provides up to date information. Also supplied with membership is a resource manual which is kept updated two yearly. External trainers, for example product representatives for the cleaning, kitchen and laundry systems, provided education which is completed by staff. The staff interviewed demonstrated good knowledge of infection prevention and control.  Resident education is conducted as required. Hand hygiene is encouraged by all staff and management. |
| 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 infection prevention and control surveillance that is undertaken is appropriate to the size of this aged care setting as demonstrated in the infection control programme. All staff are involved. An infection form is completed as soon as signs and symptoms have been identified. Monitoring is described in the infection prevention control plan inclusive of the actions to ensure residents` safety.  The clinical nurse manager completes the monthly surveillance report. Monitoring occurs for any urinary infections, eye infections, upper and lower respiratory infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections as required. The monthly analysis includes comparison with the previous month. Infections identified and any actions are reported back to the staff at the staff meetings. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policy identifies what an enabler is and that it will be voluntary and the least restrictive option to promote or maintain resident independence and safety.  There were no enablers or individual restraints in use at the time of audit. Staff are aware of the difference between an enabler and a restraint. This is included in the restraint and challenging behaviour education last presented in April 2016.  There is a door between the reception area and the resident bedroom area which has a punch number key lock on it. It is used for safety reasons only. It does not impair resident movement as the key pad number is on the residents’ side of the door and it is a switch to enter from reception. Residents were observed coming and going as they wished on both days of audit. This is identified in the policy as environmental restraint and all residents and family/whānau are made aware of this prior to admission. This was confirmed by residents and family/whānau during the audit. Policy shows that no monitoring or assessment is required. Staff confirmed there are no residents who cannot exit the door when they wish. |

# 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 1.3.3.3  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. | PA Moderate | Resident records were randomly selected and none evidenced interRAI assessments being completed. The clinical manager interviewed was able to demonstrate the system for collating electronic record evidence of the interRAI assessment for those that had been completed either on admission to the facility or as part of the six monthly review/evaluation process. | Eight of 27 residents have a completed, up to date interRAI assessment. | Provide evidence of all residents having an up to date interRAI assessment.  180 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.