

# Orongo Lifecare Limited

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## 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 Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Orongo Lifecare Limited

**Premises audited:** Orongo Rest Home

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

**Dates of audit:** Start date: 11 April 2017 End date: 11 April 2017

**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:** 40

# Executive summary of the audit

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## Introduction

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

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

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

## Key to the indicators

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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Orongo Rest Home provides rest home and secure dementia level care for up to 46 residents. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the services contract with the district health board. The audit process included review of policies and procedures, sampling of residents' and staff records, observations and interviews with residents, families, clinical and non-clinical staff and a general practitioner.

There were two areas for improvement identified at the previous audit related to pain assessments and medication management, these have now been addressed. From this surveillance audit, there are no new areas for improvement.

## 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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There are processes to access interpreting and translating services as required. Communication that is reflective of the organisation's open disclosure policy is evidenced.

There is a documented complaints process in place that complies with the Code. The complaints register records all complaints, dates and actions taken. There are no outstanding complaints.

## 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.

Business plan and quality and risk management plans document the organisational purpose, mission and goals of the service. The plans are reviewed annually, with ongoing monitoring through monthly governance meetings.

The facility is managed by an experienced and suitably qualified facility manager. The facility manager is supported by a clinical leader, who is a registered nurse.

Quality management data is collected and discussed at quality and staff meetings. There is an implemented internal audit programme which is part of the monitoring of the quality and risk management system. Corrective action plans are in place where necessary. Adverse events are documented and there is evidence of analysis of this data as part of the quality processes.

Policies and procedures are reflective of legislative requirements and good practice. The policies are regularly reviewed, with staff only having access to the current version.

Practising certificates are current for all registered nurses, one enrolled nurse and associated health professionals. Staff records have the required information, including staff education records. Staff report good access to the orientation programme and ongoing education, with records of these being maintained.

There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. The facility manager and senior staff are rostered on call after hours.

## 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.		Standards applicable to this service fully attained.
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The nursing staff are responsible for the development of residents' care plans. Care plans are evaluated, reviewed and amended every six months or when there is any change in condition status of the resident. Assessments are developed and evaluated within the required time frames.

Planned activities are appropriate to the resident's assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place. There are 24-hour activities plans for the residents living in care plans the dementia unit.

The medication management system complies with legislation and best practice guidelines for aged care. Medications are administered by nursing staff with current medication competencies.

Nutritional needs of residents are provided in line with nutritional guidelines and residents with special dietary needs are catered for. The kitchen was observed to be clean, tidy and meets food safety standards.

## **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.

There is a current building warrant of fitness in place. There have been no changes to the current layout of the service since the last audit.

## **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.

The organisation implements policies and procedures that support the minimisation of restraint. There were no restraints and five enablers in use at the time of audit. When enablers are used, these are voluntary for the comfort and safety of residents in response to individual requests. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

## 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 infection surveillance undertaken is appropriate to the size and type of the facility providing rest home and dementia level of care. Results of the surveillance are acted upon, evaluated and reported to staff and management. General practitioner, or other specialised input, is sought as required. Staff and residents reported that they are informed of any infection issues within the facility.

## 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	17	0	0	0	0	0
Criteria	0	40	0	0	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

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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
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>There is a complaints and concerns policy which meets the requirements of the Code of Rights. There is a flowchart associated with the policy to assist staff in understanding the process for complaints management. Residents and their families receive a copy of the policy in the welcome pack and there are copies throughout the facility.</p> <p>All concerns and complaints are recorded and managed according to policy. A register is maintained by the facility manager and complaints are covered at the governance meetings and reported to the owner immediately. The register is updated as required to capture all complaints, dates and actions taken.</p> <p>Training on the complaints policy and open disclosure is provided to staff annually.</p> <p>There has been one external complaint received and reviewed by the Health and Disability Commissioner (HDC), with no further actions required from the HDC investigation. The service has voluntarily implemented improvements for the accepting and admission of new residents because of the complaint. The resident's files sampled, interviews and observations at the time of audit evidenced appropriate management of acute and chronic conditions, appropriate medication usage, communication with family and the general practitioner, management of continence products, access to food and assistance with feeding and access to call bells.</p> <p>There are no outstanding internal or external complaints.</p>

<p><b>Standard 1.1.9: Communication</b></p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The cultural policy notes interpreters will be accessed if required. Prior to admission of residents who do not speak English, a senior staff member will offer the availability of the interpreting services to the resident and/or their family. This service can be contacted through the DHB. Files sampled of residents who do not speak English show there are effective methods of communication implemented.</p> <p>Evidence was seen that all aspects of care and service provision are discussed with the resident and their family/whanau prior to/or at the admission meeting. The residents and family/whanau report that communication is open and honest. Open disclosure is documented and is noted on incident forms.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Orongo Rest Home provides rest home and dementia level of care for up to 46 residents. There is a 15-bed secure dementia unit and two rest home wings (31 beds). At the time of audit there were 15 residents living in the dementia unit and 25 in the rest home sections. A resident assessed at different level of care has dispensation to provide the increased level of care at the service. There are appropriate levels of equipment and staffing to meets the needs of this resident.</p> <p>The service mission is documented in the information pamphlets and is known by staff interviewed. The business plan was sighted which defines the scope, direction and objectives of the organisation as well as the monitoring and reporting against the objectives. The plan is reviewed annually. The facility manager provides a monthly report to the director, which covers key aspects of service delivery. Any items inclusive of compliments and complaints, issues with training, property and environment are transferred onto the organisation's risk register to ensure it is current. There is a monthly governance meeting to review the progress towards achieving organisational goals.</p> <p>The facility manager has delegated responsibilities to keep the director informed of any issues or concerns that may impact the business. The facility manager is an enrolled nurse with a current annual practising certificate and management experience. They have managed the service for over 12 years. The facility manager is supported by a clinical leader, who is a registered nurse. The facility manager maintains their clinical knowledge on health issues related to the resident groups at the service, through ongoing education. The facility manager has been involved in at least eight hours' professional developed (eg aged care association updates) related to management of an aged care service.</p> <p>The resident satisfaction survey (July 2016), records 91% overall satisfaction with the services provided at Orongo Rest Home. The actions implemented from the satisfaction survey are documented in the quality meeting minutes. The residents and families interviewed reported satisfaction with the services provided.</p>
<p><b>Standard 1.2.3: Quality And Risk Management</b></p>	FA	<p>There is a quality and risk management framework which includes the quality plan. The 2017 plan details the quality system, quality structure and sets quality goals for 2017. The governance team develops the quality plan</p>

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>and goals, maintains document management and control in the facility, and is responsible for monitoring and reporting progress against the quality goals in the monthly report to the director. The strategies for the staff to be involved in and understand the quality system is documented in the quality plan. The staff interviewed demonstrated understanding of the quality plan, through reading the plan, participating in monthly policy review and being informed of outcomes of quality activities at staff meetings and notice boards.</p> <p>The facility manager is responsible for providing leadership in the facility and for the implementation of the plan, providing educational support for staff and registered nurses. Any issues or risks are reported to the director.</p> <p>Policies and procedures are developed by an aged care consultant, along with their own organisational policies and procedures. The policies and procedures sampled are relevant to the scope and complexity of the service and reflect current accepted good practice. There is a two-yearly plan for the review of all service policies (or more often if there are legislative or best practice changes). The infection control policies are reviewed annually. Policies and documents are version controlled. Staff only have access to the most current version of policies and procedures.</p> <p>The internal audits identify the purpose of the audit, how the information is gathered, frequency, who to report findings to and a checklist of the area audited. There are internal audits or surveys scheduled for all aspects of service delivery. The results of the internal audit and any other quality data collected are collated and analysed monthly. When shortfalls are identified, the service then developed an audit corrective action plan. The corrective action planning includes an improvement plan, how the improvement is to be measured and are re-audited to see if the desired improvement was achieved. Internal audits sampled from November 2016 and to date in 2017 include corrective action plans that have been completed. The quality system includes identifying the recommendations and outcomes and reporting these to staff, families and residents as appropriate.</p> <p>The business continuity and risk management plan includes the identification of actual and potential risks. Each risk is rated against the impact on the service and the likelihood of occurrence. Preventative actions are documented on either eliminating, isolating or minimising the risk.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their</p>	<p>FA</p> <p>The facility manager is aware of the essential notification requirements and these are documented in policy, including the responsibility of reporting stage three and above pressure injuries. The facility manager advised that there has been one essential notification of an outbreak (refer to 3.5).</p> <p>Adverse events are documented on an incident/accident form and these are followed up by the facility manager. Forms document follow-up actions. All incidents/accidents are reported to the registered nurse or the clinical leader on duty. Staff confirmed that they are made aware of their responsibilities in this regard during their orientation and in policy and procedures.</p> <p>The data related to adverse events is collated and reviewed monthly, which includes a trend analysis. Where trends and shortfalls are identified, corrective actions are implemented to make improvements to service</p>

family/whānau of choice in an open manner.		delivery and individual resident preventive strategies (such as falls minimisation).
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	<p>There are policies and procedures on human resources management. Annual practising certificates of all RNs and one enrolled nurse were verified as were those for all associated allied health professionals. The skills and knowledge required for each position within the service is documented in job descriptions which were evident on each personal record sighted.</p> <p>An orientation process is available and covers all essential components of the services provided. One newly appointed staff member interviewed found the information provided to be informative and supportive. Staff performance appraisals are performed at the end of orientation and annually, with these evidenced in the staff files sampled.</p> <p>There is an education plan for the next two years with several sessions confirmed with speakers. The 2016 and 2017 programme was sampled and evidenced that education covers contract requirements and the needs of the residents. Education is provided, in house, on line and by staff visiting external facilities. The individual records of education are maintained for each staff member and were reviewed. All relevant staff have medication competencies. The care staff who work in the dementia unit have the required national unit standards. The activities coordinator has specific education and experience in dementia care. The two registered nurses are trained in the interRAI assessment programme. Staff interviewed reported that they had good access to education and enjoyed the programme.</p>
Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	<p>There is a documented allocation of staff to complete the duty rosters. The staffing levels and skill mix policy considers the acuity levels of residents in the rest home and secure dementia unit. The rosters sampled evidenced that staffing levels comply with contractual requirements, with staff on leave replaced. There are at least three caregivers on duty in the rest home for morning and afternoon shifts (staggered finish times, with more staff on duty at the busiest times of the shift). There are two staff on duty in the dementia unit mornings and evenings, and at night there is one staff member in the dementia unit and two other care staff in the rest home. This enables the staff member in the dementia unit to be assisted as required. The facility manager and staff interviewed reported that they can manage residents with changed needs across all shifts.</p> <p>Registered nurses are on duty morning shift six days a week and on call at other times. The on-call roster is documented in the communication diary. There facility manager is on duty morning shifts Monday to Friday. There are sufficient numbers of support staff (kitchen, cleaning, laundry) to meet the needs of the residents. There is an activities coordinator five days a week. The care staff assist with the activities on weekends.</p> <p>Care staff interviewed reported that there were adequate staff available and that they could complete the work allocated to them. Residents and families interviewed reported that there was enough staff to provide them or</p>

		their relative with adequate care. Observations during the audit confirmed adequate staff coverage is provided.
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	<p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner and medication records sampled complied with legislation, protocols and guidelines. Medications are stored in a safe and secure way in the treatment rooms and locked cupboards. Medication reconciliation is conducted by the RNs when the resident is transferred back to the service. The service uses pharmacy pre-packed medication packs that are checked by the RNs on delivery. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated and identification photos are present for easy identification.</p> <p>An annual medication competency is completed for all staff administering medication and medication training records were sighted. The RN was observed administering medication correctly in the dementia and rest home wing respectively. The controlled drug register is current and correct. Weekly and six monthly stock takes are conducted and all medications are stored appropriately. There were no residents self-administering medication at the time of the audit and there is a policy and procedure for self-administration of medication if required.</p> <p>All medication charts sampled recorded the dose of the medication given, this addresses the previous area for improvement.</p>
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	<p>Meal services are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents have a nutritional information sheet developed on admission which identifies dietary requirements, likes and dislikes. The resident's weight is monitored regularly and supplements are provided to residents with identified weight loss issues. There is nutritional snacks available 24 hours a day for residents living in the dementia unit.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p>
Standard 1.3.4: Assessment  Consumers' needs,	FA	An improvement, as requested from the previous audit, was made in developing and completing pain assessments and monitoring forms for all residents with pain relief medication. The initial assessments are completed within the required time frame on admission, while care plans are completed within three weeks. The

support requirements, and preferences are gathered and recorded in a timely manner.		services used a mix of interRAI and their own paper based assessment tools Assessments and care plans are detailed and include input from the residents, family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews, the family/whanau expressed satisfaction with the support provided.
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The documented interventions in short term care plans and long term care plans are sufficient to address the assessed needs and desired goals/outcomes of residents. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies were observed and the staff confirmed they have access to adequate supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support they are receiving.
Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The planned activities are meaningful to the residents. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The activities staff reported that they modify activities based on the resident's response and interests and per the capability and cognitive abilities of the residents. Residents' files have a documented activity plan that reflects their preferred activities of choice. There are activities and diversional plans that cover a 24-hour period for the residents living in the dementia unit.  The activities coordinator develops an activity planner which is posted on the notice boards and white boards respectively. The residents were observed to be participating in a wide range of activities on the audit day. There are planned activities and community connections that are suitable for the resident's entertainment. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident's long term care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Residents, family/whanau and staff input is sought in all areas of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions in place. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.
Standard 1.4.2: Facility Specifications	FA	There is a current building of warranty of fitness displayed. There have been no changes to the layout of the building that has required the approved evacuation scheme to be amended.

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
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	<p>The service uses standardised definitions of infections applicable to aged care. The type of surveillance undertaken is appropriate to the rest home and specialist dementia service.</p> <p>There is monthly collection and collation of the types and numbers of infections in both the rest home and the dementia services. The data and reporting of the analysis is conducted by the infection control coordinator and reviewed at the quality meeting. The outcomes are fed back to the staff at the next staff meeting, with any immediate risk reported at handover and to management.</p> <p>The infection data for 2016 records an outbreak of norovirus in October 2016. The analysis during and post the outbreak includes the transition based precautions that were implemented. There was a daily reporting of infections to the DHB, individual resident short term care plans and fluid balance records were implemented for individual residents. The analysis of the management plan that was implemented identified improvements that could be implemented in the outbreak management policy. These have been actioned.</p>
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, no residents were using restraints and five bed loops that have been classified as enablers. The bed loops are handles that provide support to assist a person getting in and out of bed or to help with changing position in bed. The bed loops are used voluntarily at the residents' request and do not restrict the resident's mobility.</p> <p>There is an annual review of the restraint minimisation practices, with two uses of emergency restraint recorded in 2016. This was short term for the immediate safety of the residents (during the outbreak management period). Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff.</p> <p>The layout of the dementia unit is designed for the safe wandering of the residents. The dementia unit and grounds are separated from the rest home sections.</p>

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## **Specific results for criterion where corrective actions are required**

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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.

No data to display
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## **Specific results for criterion where a continuous improvement has been recorded**

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

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

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

No data to display

End of the report.