

Leighton House Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Leighton House Limited

Premises audited: Leighton House

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

Dates of audit: Start date: 3 May 2017 End date: 4 May 2017

Proposed changes to current services (if any): Proposal is to increase from 20 dual service hospital level care beds (including geriatric services and medical services) up to 25 using five rooms currently used as rest home beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 38



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
Yellow	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
Red	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

Leighton House is operated by Dementia Care New Zealand. The service provides care for up to 50 residents requiring rest home or hospital (medical and geriatric) level care. On the day of the audit, there were 38 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The service is managed by a clinical manager (registered nurse), who commenced the role in March 2017. He is supported by a operations manager who has been in the role since 2013.

The organisation has a wide range of support available including: a clinical director, national clinical manager, quality system manager, education coordinator and mental health nurse, operational management leader and owners/directors.

Residents, relatives and general practitioners (GP) and nurse practitioner (NP) interviewed spoke positively about the service provided.

The service has exceeded the standards around: infection control, activities, and quality improvements.

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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The service endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrated an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented and complaints and concerns are actively managed and well documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated and are appropriate to the needs of the residents. A clinical manager and operations manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan

is being implemented and includes in-service education and competency assessments. A professional development project/plan is in situ for regulated staff. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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The clinical manager and registered nurses take responsibility for managing entry to the service. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. Residents interviewed confirmed that they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting with a focus on community involvement and maintaining residents' past and present interests. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building has a current warrant of fitness. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. All rooms are single and personalised. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are well utilised for group and individual activity. The dining room and lounge seating placement encourages social interaction. Other outdoor areas are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely. The staff maintain a tidy and clean environment.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. One restraint and no enablers were in use.

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.
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The infection control programme is appropriate for the size and complexity of the service. The infection control nurse (registered nurse) is responsible for coordinating the infection control programme and providing education and training for staff. The infection control manual outlines the scope of the programme and includes a comprehensive range of policies and guidelines. Information is obtained through surveillance to determine infection control activities.

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	1	49	0	0	0	0	0
Criteria	3	98	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

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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (five healthcare assistants, two registered nurses (RNs), one activity coordinator, the operations manager and clinical manager), reflected their understanding of the key principles of the Code.
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	The service has policies and procedures relating to informed consent and advanced directives. All resident files reviewed include signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.
Standard 1.1.11: Advocacy And	FA	Information about the National Health and Disability Advocacy Service is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents are able to participate in as much as they can safely and desire to do. They have also created ongoing relationships with community groups that visit the facility. Resident meetings are held monthly. Monthly newsletters are provided to residents.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of complaints process. Information about complaints is provided on admission. Interview with residents (four rest home and two hospital level of care) and relatives confirmed an understanding of the complaints process. There is an up-to-date online complaint register. There have been five complaints (verbal and written) received from February 2016 to current date. All complaints reviewed had noted investigation, timeframes and corrective actions, including letters of acknowledgement. Management operate an open-door policy.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The operations manager, the clinical manager or registered nurses discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Six residents (four rest home and two hospital) and five relatives (three rest home and two hospital) interviewed reported that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p>	FA	<p>Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives are positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names.</p>

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff have received training.
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	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There is one resident who identified as Māori living at the facility. There are links to the local marae. Māori consultation is available through the documented Iwi links and Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All healthcare assistants interviewed were aware of the importance of whānau in the delivery of care for Māori residents.
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	The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident's spiritual and cultural needs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff house rules are discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with healthcare assistants confirmed their understanding of professional boundaries, including the boundaries of the Healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Healthcare assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with five healthcare assistants could describe how they build a supportive relationship with each resident. The service uses a "best friends" approach to caring for residents.
Standard 1.1.8: Good Practice Consumers receive services of an	FA	Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available 7 days a week, 24 hours a day. There are a number of GPs caring for the residents

<p>appropriate standard.</p>		<p>at Leighton house. A general practitioner (GP) and/or nurse practitioner visits the facility on a weekly basis and an after-hours' service is provided at the local public hospital. The GP or nurse practitioner reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed is satisfied with the level of care that is being provided.</p> <p>The service receives support from the district health board, which includes nurse specialist's visits. A physiotherapist weekly. A dietitian is available for consultations. There is a regular in-service education and training programme for staff. A podiatrist is on-site every six weeks. The service has links with the local community and encourages residents to remain independent. Leighton House is benchmarked against other DCNZ facilities providing rest home and hospital level care.</p> <p>Clinical managers and operational managers attend DCNZ six-monthly seminars to ensure that professional development requirements are achieved and staff are updated as to current best practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Relatives interviewed (three rest home and two hospital) stated they were welcomed on entry and given time and explanation about the levels of care provided and services and procedures. There is documented evidence of full and frank open disclosure regarding changes to their relative's health including incident/accidents, medication changes, GP visits and infections. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. Resident meetings are held monthly. A family focus meeting occurs annually and provides relatives with an opportunity to feedback on the service. Relatives receive newsletters to keep them informed on facility matters, activities and topics of interest.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Dementia Care New Zealand (DCNZ) is the parent company for Leighton House The service provides care for up to 50 residents requiring hospital, (medical and geriatric) and rest home level care. On the day of the audit there were 38 residents (14 at hospital level care and 24 at rest home level care). There were no residents under the medical component. There was one rest home respite resident. All residents were under the aged care contract. There are currently 20 dual-purpose beds. This audit also included verifying a further five rest home rooms as suitable as dual-purpose.</p> <p>There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. DCNZ has an overall 2016 – 2017 business/strategic plan based on "our services", "our people", "our environment" and the "sharing of experiences". The business plan is regularly reviewed. The organisation has a philosophy of care, which includes a mission statement.</p>

		<p>The clinical manager/registered nurse has been in the role since March 2017 and is supported by the national clinical manager who has been on-site prior to the audit to assist with the clinical manager's orientation. The clinical manager attended DCNZ clinical manager's seminar in April 2017</p> <p>The operations manager (non-clinical) of Leighton House has been in the role since August 2013. The operations manager reports to the operational management leader at head office. The operational manager is supported by an organisational quality systems manager, education coordinator, clinical director and owners/directors at head office. The operations manager has attended at least eight hours of professional development including health and safety transition training. The operations manager attends DCNZ seminars and has completed more than eight hours training related to managing a rest home and hospital in the past year.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the temporary absence of the operations manager, the clinical manager covers the operations manager's role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a quality plan that includes quality goals and risk management plans for Leighton House. The quality programme is managed by the operations manager and clinical manager. A quality systems manager for the organisation oversees the quality programme ensuring all aspects of quality management is implemented.</p> <p>Interviews with staff confirmed that there is discussion about quality data at various facility meetings including monthly quality improvement meetings and clinical meetings. There is documented evidence in meeting minutes of quality data, trends and analysis. Minutes and the staff monthly bulletin (displayed on the staff noticeboard) contain topical information and quality data. Organisational policies meet all current requirements and are reviewed at head office. Staff have access to the policy manuals.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. The operations manager completes environmental and non-clinical audits. The clinical manager undertakes all clinical audits. The internal audit programme continues to be implemented and all issues identified had corrective action plans and resolutions. The quality systems manager</p>

		<p>completes compliance site audits.</p> <p>Annual welfare guardian welfare surveys were completed in October 2016. Results were published in the family newsletter. Quality improvements raised and implemented were an increase in activities and ensuring cultural preferences and special dietary needs are captured and communicated to staff. The service has a cultural advisor on staff.</p> <p>The service has a Health and Safety Committee which comprises of a health and safety officer, health and safety representative, manual handling advisor, restraint coordinator and care staff. All committee members have completed external health and safety education. Health and safety objectives for 2017 are known by staff and include a reduction of staff accidents and minimisation of falls.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy. An online incident/accident register is maintained. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality improvement and clinical meetings including actions to minimise recurrence. A registered nurse conducts clinical follow up of residents. Fourteen incident forms reviewed demonstrated that all appropriate clinical follow up and investigation had occurred following incidents. Discussions with the operation's manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications and were able to provide examples.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Current practising certificates were sighted. Seven staff files were reviewed (one clinical manager, two registered nurses, two healthcare assistants, one activities coordinator and one cook) and there was evidence that reference checks and police vetting were completed before employment. Annual staff appraisals were evident in all staff files reviewed for those who have been with the service over twelve months. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation was evidenced and staff described the orientation programme. The service uses the "Best Friends" approach to caring for residents and staff complete an in-service education programme on this approach to care.</p> <p>The in-service education programme for 2016 has been completed and the plan for 2017 is being</p>

		<p>implemented. The service identified not all staff were able to attend education sessions and developed a workbook.</p> <p>The organisation has developed a user-friendly caregiver orientation workbook that includes a self-directed learning package that aligns with the first year of education requirements. The workbook includes the policy and comprehension questionnaire. A second-year workbook has been developed to cover the mandatory requirements of the two-yearly training calendar. Staff receive this workbook at their first annual appraisal.</p> <p>The service uses the “Best Friends” approach to care and 32 of 42 staff have completed the internal education programme on this topic. The clinical manager and registered nurses are able to attend external training, including sessions provided by the local DHB. The clinical managers within the organisation attend biannual DCNZ National Forums in advanced nursing practice, competency driven (total of 40 hours annually). Eight hours of staff development or in-service education has been provided annually. All RNs have completed first aid training. The organisation has an education coordinator who is a registered psychiatric nurse. The clinical director leads the professional development project across the organisation.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. Leighton House roster identifies there is sufficient staffing cover for the safe provision of care for rest home and hospital residents.</p> <p>The building is single storey with two adjoining wings.</p> <p>The clinical manager (RN) works full-time Monday to Friday and is available on-call 24/7. Additionally, there is a registered nurse on duty on each shift, seven days per week. There are seven healthcare assistants on duty on the morning and afternoon shifts and two healthcare assistants on night duty (with an RN).</p> <p>Staff are visible, available and attend to call bells in a timely manner as confirmed by all resident and relatives interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and relatives interviewed report there are sufficient staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being held securely in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission.</p>

identifiable, accurately recorded, current, confidential, and accessible when required.		Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care staff. Individual resident files demonstrate service integration with only medication charts held on the electronic medication management programme.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical manager screens all potential residents prior to entry. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement form in use aligns with the requirements of the ARRC services agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur.
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 management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication round sighted. There was evidence of three-monthly reviews by the GP or NP. All RNs and HCAs that administer medicines are competent and have received medication management training. The facility uses a robotic packed medication management system for the packaging of all tablets and an electronic medication management system for charting and recording administration. The RN on duty reconciles the delivery of medication and documents this. There were no residents self-administering medication on the day of audit. There are no standing orders.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met	FA	All meals are prepared and cooked on-site. There is a four-weekly seasonal menu which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. All food preferences are met. Staff were observed assisting residents with their meals and drinks. Supplements are provided to

<p>where this service is a component of service delivery.</p>		<p>residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. All food services staff have completed food safety and hygiene and chemical safety.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service has an accepting/declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available or the service cannot provide the level of care required.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The interRAI initial assessments and reviews are evident in printed format in all resident files. Resident files reviewed identify that risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation. Additional assessments for management of behaviour, pain, wound care, nutrition, depression score, falls and other safety assessments including restraint are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plans are resident-focused and personalised. The care plans describe the resident goals, supports and interventions required to meet desired goals as identified during the ongoing assessment process. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Residents confirmed on interview they are involved in the care planning and review process. There is evidence of allied health care professionals involved in the care of the resident. Long-term care plans sampled have been reviewed and updated in a timely manner following a decline in health. Short-term care plans are developed following a change in health. Interventions documented are comprehensively detailed to address the desired outcome/goal. Integration of records and monitoring documents are well managed.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses (RNs) and healthcare assistants follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse or wound care specialist nurse). If external medical advice is required, this is actioned by the GPs or nurse practitioner. Staff have access to medical supplies (eg, dressings). Continence products are available and resident files include a continence assessment and plan as part of the plan of care.</p> <p>Wound assessments and short-term care plans were in place for twenty-one wounds (one surgical wound, twelve skin tears, three corns, two moisture lesions, one lesion, one cellulitis and one skin abrasion). Wound assessments, plans and evaluations are in place for all wounds. The RNs have access to specialist nursing wound care management advice if required. A corrective action plan has been implemented following an increase in skin tears and a manual handling update has been provided to staff.</p> <p>Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The service employs a diversional therapist and two additional activities staff (both undertaking diversional therapy training) totalling seventy hours per week over seven days. The activity programme is planned around meaningful everyday activities and special events (a calendar template is provided by head office). There is a range of activities both within and external to the facility, one-to-one and group activities and numerous groups coming to the facility from the community.</p> <p>There is evidence that the residents have input into review of the programme by one-to-one feedback, the resident's monthly meeting, a survey specific to activities and the resident survey and this feedback is considered in the development of the residents' activity programme. The activity programme is developed weekly. A copy of the activity plan is displayed on the noticeboard. The staff also remind residents of the activities that are occurring daily.</p> <p>The service has a van which can accommodate mobility aids. Outings occur weekly and residents reported visiting other aged care facilities to join in activities once a week.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). The activities documentation in the resident files sampled reflected the specific requirements of each resident. Residents interviewed evidenced that the activity programme had a focus on maintaining independence and reducing boredom.</p> <p>In the files reviewed the recreational plans had been reviewed six-monthly.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six-monthly or earlier if there was a change in health status. There was at least a three-monthly review by the GP or nurse practitioner. All changes in health status were documented and followed up. Reassessments have been completed using the interRAI assessment tool for all residents who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs or the nurse practitioner. Referrals and options for care are discussed with the family as evidenced in files. The registered nurses provided examples of where a resident's condition had changed and the resident was reassessed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies and procedures in place for the disposal of waste and hazardous material. There is an accident/incident system for the investigating, recording and reporting of all incidents. Chemical supplies are kept in locked cupboards in service areas. The contracted supplier provides the chemicals, safety data sheets, wall charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment (PPE) is readily available to staff and at audit staff were sighted using PPE appropriately.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are</p>	FA	<p>The building holds a current warrant of fitness, which expires March 2018. There are proactive and reactive maintenance management plans in place. Contracted providers test equipment. Electrical testing of non-hard wired equipment was last conducted in February 2017. Medical equipment requiring servicing and calibration was last conducted in December 2016. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors or</p>

<p>fit for their purpose.</p>		<p>contractors to the facility. Residents have adequate internal space to meet their needs. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents are designated drivers.</p> <p>There are currently 20 dual-purpose beds. This audit also included verifying a further five rest home rooms as suitable as dual-purpose. All rooms are large enough for mobility equipment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>In the facility seventeen rooms have an ensuite, a further twenty bedrooms share an ensuite between two rooms and thirteen rooms use communal showers/toilets. There are adequate communal showers/toilets and they are conveniently located. There are separate toilets for staff and visitors. All showers/toilets have appropriate flooring and handrails. There are vacant/occupied signs, privacy locks and shower curtains. Call bells are available in all shower/toilet areas. All bedrooms have a hand basin and fixtures and fittings along with floor and wall surfaces meet infection control guidelines.</p> <p>There was evidence that hot water temperatures meet regulations. Rooms selected randomly each week have their water temperature audited.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All bedrooms are single and of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Residents interviewed all spoke positively about their rooms. Rooms can be personalised with furnishings, photos and other personal adornments and the service encouraged residents to make the room their own.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The service has a number of lounge/dining areas that could be used for activities. All areas are easily accessed by residents and staff. Residents are able to choose where they wish to sit or dine and are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely and socialise.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	<p>FA</p>	<p>All linen and personal clothing is laundered on-site. The care staff process laundry in the course of their duty. There is a defined clean and dirty area of the laundry and an entry and exit door. There is</p>

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>also entrance via a sluice room. The laundry is well equipped and the machinery is regularly serviced. Adequate linen supplies are sighted. Chemicals are stored in a locked chemical room.</p> <p>The cleaner's cupboard containing chemicals is locked. All chemicals have manufacturer labels. Cleaning trolleys are well equipped and stored in locked areas when not in use. Staff demonstrated knowledge of processes for laundering and cleaning and the safe use of chemicals. The environment on the day of audit was clean and tidy. The residents interviewed are satisfied with the cleanliness of the communal areas and their bedrooms.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an emergency response and civil defence plan to guide staff in managing emergencies and disasters. Emergency response and first aid is included in the mandatory in-service training programme. There is a first aid trained staff member on every shift. Staff records sampled evidences current training regarding fire, emergency and security education. There is a letter from New Zealand Fire Service reviewed dated 9 April 2002 advising approval of fire evacuation schemes. The last trial evacuation was held on 28 February 2017 and has been held six-monthly.</p> <p>Information in relation to emergency and security situations is readily available for service providers and residents. There are two fully stocked civil defence kits. There is a gas barbeque should the mains gas supply fail. The service has adequate stored water including water tanks for an emergency. There is an appropriate call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are accessible, within easy reach and are available in resident areas including bedrooms, ensuite toilet/s, the lounge and dining room.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated with radiator heating and kept at a comfortable temperature. Residents and relatives interviewed confirm the environment and the bedrooms are warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	<p>FA</p>	<p>Leighton House has an established infection control (IC) programme that is being implemented. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. The clinical manager is the designated infection control nurse with support from the registered nurses and national clinical manager. The IC team meets as part of the quality team meeting to review infection control matters.</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually. IC is supported through expert national education biannually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Leighton House. The infection control (IC) nurse has maintained their practice by attending infection control updates. The infection control team (the quality team) is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control nurse who has completed training to ensure knowledge of current practice. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and lab staff that advise and provide feedback/information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported at the various facility meetings. Individual resident infection control summaries are maintained. All infections are documented on the infection monthly online register. The surveillance of infection data assists in evaluating compliance with infection control practices.</p> <p>There was a suspected respiratory outbreak in May 2016, which was not confirmed by subsequent diagnostic methods utilised. Contact and liaison with the Public Health Department and notification to the DHB were evidenced. Information provided to staff, residents and families during the suspected outbreak was sighted in the infection control folder. A debrief meeting was held and minutes were sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a restraint policy in place that states the organisations philosophy to restraint minimisation. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Currently the service has one resident requiring the use of a restraint (tray table) and no residents using an enabler.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint coordinator for the facility is a registered nurse who has defined responsibilities included in their job description. Only staff that have completed a restraint competency assessment are permitted to apply restraints. Restraint competencies are completed annually and there is ongoing education including challenging behaviours. Quality and clinical meetings include discussion on restraint.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous</p>	<p>FA</p>	<p>Assessments are undertaken by the clinical manager or registered nurses in partnership with the resident and their family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available,</p>

assessment of consumers is undertaken, where indicated, in relation to use of restraint.		which is completed for residents requiring an approved restraint for safety. Ongoing consultation with the resident and family/whānau was also identified. Falls risk assessments are completed three-monthly. A restraint assessment form was completed for the one resident requiring restraint (sighted). Assessments consider the requirements as listed in Criterion 2.2.2.1 (a) - (h). Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation with the consumer (as appropriate) or family/whānau and the facility restraint coordinator. Overall, each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use is used as a last resort in keeping with the restraint minimisation policy. The resident file reviewed requiring the use of a restraint, evidenced that consent was obtained on consultation with the resident and relative and the consent form was signed by the family member, restraint coordinator and GP.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Evaluations occur three-monthly as part of the ongoing reassessment for residents on the restraint register and as part of their care plan review. Families are included as part of this review where possible.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly RN/clinical meetings and quality meetings.

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.

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Benchmarking reports are generated throughout the year and an annual review of the data is completed. Quality improvement forms are utilised at Leighton House and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. The service is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified.</p>	<p>The service is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc. As a result of quality data collected, the clinical manager feeds back monthly to staff at handover and staff meetings, issues arising and identified trends or issues. Any identified common themes around incidents/infections etc. results in further education and updates at handovers between shifts and meetings. Documentation reviewed identified that strategies are regularly evaluated. Leighton House focused on pressure injury prevention and falls prevention in 2016.</p> <p>The service implemented the following strategies that included (but not limited to): (i) a workshop for RNs and healthcare assistants on pressure area risk assessments; (ii) compulsory in-service on pressure</p>

			<p>area management and hydration and nutrition; and (iii) commencing turn charts and nutrition charts, for those identified at risk. Organisational benchmarking reports reviewed identified that the service has remained under the organisational target range of 0.08 per 1000 bed nights at 0.00 per 1000 bed nights for the last twelve months.</p> <p>The service implemented the following strategies around falls prevention that included: (i) a falls competency package; (ii) education sessions on falls prevention, importance of hydration; (iii) falls mapping; (iv) purchase of equipment eg, sensor mats; (v) physiotherapy review of residents following a fall and; (vi) encouraging and/or assisting residents to participate in the exercise programme. As a result of the strategies implemented, the facility has remained below the organisational target range of 6.38 falls per 1000 bed nights at 5.18 over a twelve-month period.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>All residents are assessed at admission and in an ongoing manner to establish interests and skills. A plan is developed for the residents around activities. The activity programme has been reviewed and improved with resident input, resulting in significantly higher attendance at activities.</p>	<p>The results of the 2016 resident survey evidenced that there was a need to improve and further develop the activity programme.</p> <p>Activities are now provided seven days per week. Residents are encouraged to make suggestions and provide feedback on activities at monthly resident meetings.</p> <p>Residents have been growing their own vegetables, which are cooked and eaten by residents. Other activities include: musical entertainment, spontaneous activities, BBQ's, cognitive therapy activities, pet therapy, art therapy, poetry and drama, movies, cookery club and gardening. On the days of audit, residents and visitors were observed joining in activities and the musical entertainment.</p>

			<p>During the week and at weekends, the Leighton House van transports residents to events happening in the local community. The residents visit other aged care facilities in the local area and participate in games, events and competitions.</p> <p>Residents and family members interviewed reported enjoying the variety and diversity of the programme and the ability to attend activities of interest. Residents meeting minutes sighted evidenced significantly increased attendance at the activity programme in 2016 to current date.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. All infections are individually logged monthly. The data has been monitored and evaluated monthly and annually and is benchmarked internally.</p>	<p>The service implemented the following strategies around reducing the incidents of urinary tract infections (UTIs) that included: (i) education on the importance of hydration; (ii) education session presented by a microbiologist at clinical managers' study day on the prevention and management of UTIs; (iii) introduction of extra fluid rounds in warmer weather and; (iii) establishing a toileting regime that meets individual resident's needs. As a result of the strategies implemented, the facility has remained below the organisational target range of 1.51 UTIs per 1000 bed nights at 1.36 over a twelve-month period.</p>

End of the report.