# Portwell Care Limited - Cook St Nursing Care Centre

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Portwell Care Limited

**Premises audited:** Cook St Nursing Care Centre

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

**Dates of audit:** Start date: 18 October 2017 End date: 19 October 2017

**Proposed changes to current services (if any):** The prospective providers are planning to increase the ‘swing beds’ from two to seven.

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

# Executive summary of the audit

## Introduction

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

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

## General overview of the audit

This provisional audit was undertaken for Portwell Care Limited, a limited liability company with two directors, both of whom were interviewed. They are proposing to purchase Cook Street Nursing Care Service with a planned handover date 22 November 2017. The service provides rest home and hospital level care for up to 30 residents. One of the directors is a registered nurse who will take on the facility and clinical management role. Staff, residents and families have been informed of the change to service. Residents and family spoke positively about the care provided and hope the change of ownership will not change the family environment of the facility.

The audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff, and a general practitioner.

There are two improvements required in relation to policies and procedures and the environment. The corrective actions required from the last audit have resulted in improvements.

## Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident’s individual needs.

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

The prospective provider will work with the present business and quality and risk management plans and review these over time. There is evidence of the direction, goals, values and scope of service being documented for the organisation. Monitoring of the services provided to the governing body is monthly and effective.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents and the prospective provider will not make changes to the staffing levels.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people.

## Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

The facility meets the needs of residents and was clean and maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. The majority of the laundry service is undertaken offsite, with a small inhouse laundry providing residents’ personnel and some facility laundry. Auditing for compliance with required standards is undertaken.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Residents and family members reported timely staff response to patients’ needs. Security is maintained by staff.

## Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Two enablers and eight restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

The infection prevention and control programme, led by a trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 48 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 2 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| 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 | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the residents’ records. Staff were observed to gain consent for day to day care. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The nurse manager interviewed was able to discuss support services available in the community and how to contact them if required. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents’ family and friends. Family members interviewed stated they always felt welcome and were included in activities when they visited and were comfortable in their interactions with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The concerns, complaints and suggestions policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and forms are available at reception and in the nurses’ room. Family and residents interviewed knew how to do so, and expressed a high degree of satisfaction with the service being provided.  The facility and clinical nurse managers are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. The complaints register was reviewed with the clinical nurse manager. This showed that one complaint has been received this year, to date, and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. The action taken showed staff were involved in the resolution and learnings were being monitored with the staff member. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and families interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, admissions agreement and in discussions with staff. The Code is displayed in the main foyers areas together with information on advocacy services, how to make a complaint and feedback forms. The prospective provider interviewed was able to demonstrate a good understanding of consumer rights, has worked in management in the aged care sector for many years and has links with the Health and Disability Commissioner’s office. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and individual choices.  Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by participating in community activities and clubs of their choosing. Care plans were resident centred and included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. |
| 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 | Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers and incorporates the Te Whare Tapa Wha model. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Residents who affiliate with their Maori culture and their whanau were unavailable to be interviewed at the time of audit, however the residents’ files showed open disclosure in regular contact/discussions and meetings. Staff interviewed reported that they acknowledge and respect their individual cultural needs and were able to provide examples of this. |
| 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 | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident’s personal preferences, required interventions and special needs were included in care plans reviewed and incorporated in the care that residents received. The resident satisfaction survey confirmed that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. One of the 11 general practitioners (GPs) interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff know how to access interpreter services, although reported this was rarely required due to all current residents able to speak English. Examples were provided of support for past residents who had English as their second language. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | There is a business plans, 2016-2017, which the prospective provider will work with and develop their own plan over time. This outlines the purpose, values, scope, direction and goals of the organisation. The documents describe key performance indicators. The facility manager and quality co-ordinator provided a sample of reports to the owner; these showed adequate information to monitor performance is reported including, occupancy, incidents and complaints. A quarterly meeting occurs with the managers and the owner.  The prospective providers spoke of implementing a flat management structure with one of the directors taking on the role of facility and clinical management. The other will take on a role with maintenance and some business management. One of the directors is a nurse with a current annual practising certificate and has held senior management posts in residential and secondary care for many years. The prospective provider keeps current by being a member of the NZ Aged Care Association, NZNO Gerontology Group and College of Nursing. The prospective providers have supports for financial and business management.  The service holds contracts with the DHB for hospital level care which includes, palliative and medical service, as well as rest home services. Twenty seven residents were receiving services under these contracts, seven rest home residents and eighteen hospital level residents, one of whom was palliative care and one under 65 years of age, at the time of audit. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The prospective providers stated they will be supported by the present owner and management over a two-week period to allow for a seamless handover. After this time the facility manager, who is leaving after the handover, has stated they will be available to provide support, such as to stand in when the prospective owners are away. The present clinical nurse manager will take up a role as a senior RN and the nursing team leader intends to stay in her present position. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents, complaints, clinical and non-clinical audit activities, a regular resident and family satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint minimisation. The facility manager and the contracted quality co-ordinator described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The prospective owners will continue with the present processes and review them over time. They are familiar with the Health and Safety at Work Act (2015) and will implement the requirements.  The quality co-ordinator provides monthly analysis and trending of audit data, which is benchmarked against previous years and with national averaged data. This information is provided to the managers and the owner. Minutes of the integrated quality meeting (full staff meeting), reviewed confirmed data is discussed and corrective actions documented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed a high degree of satisfaction with services provided. A fall in satisfaction in one area, from the previous year, related to the environment. This has been actioned to the satisfaction of the residents.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Six manuals contain the policies and procedures, these are available to staff in hard copy and electronic. These are reviewed on a two-yearly basis. Review of policies did not show reference to current legislation, new policies were not integrated to reflect the organisation. Cleaning and laundry staff were using policies which were not current and were different from the policies in the manual. The prospective provider stated that they will be undertaking a review of policies and procedures. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse and near miss events on an accident/incident form. These are reviewed by the RN and clinical nurse manager promptly. Sixty one events have been documented this current year. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owner and staff through their meeting.  The facility, clinical manager and prospective manager are aware of the requirements for essential notification reporting, including for pressure injuries. They advised that one pressure injury has recently been notified to the Ministry. No other significant events have occurred since the previous audit. |
| 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 | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, validation of qualifications and practising certificates (APCs) for all health professionals employed and contracted. A sample of staff records (RNs, care assistants, cleaning, and managers), reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after six weeks then annually.  Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed core competency requirements, and a number have completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. The clinical nurse manager is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency The prospective owner has enrolled to undertake interRAI training. Presently there are three RNs who have undertaken interRAl training and annual competency. Records reviewed demonstrated completion of the required training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mix to provide safe service delivery, 24 hours a day, seven days a week. The interRAI data is not presently being used as a tool for assessing the acuity of the residents. The prospective provider has no plans to change the roster, but has a tool that she has used in a previous facility, and will look at moving to use this tool. The minimum staffing level is at night, with one RN and a care assistant on duty. The facility adjusts staffing levels to meet the changing needs of residents. The facility and clinical nurse manager are on call afterhours; this is not often used. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a two week roster confirmed adequate staff cover has been provided, with staff replaced in any planned or unplanned absence. All staff members have a current first aid certificate and there is RN coverage in the hospital on all duties. RNs with specific duties for infection control and restraint have a dedicated two hours a week for these roles.  Other contracted services include, podiatry, physiotherapy, a gardener and quality co-ordinator. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely of site in a commercially secured location and not visited at time of audit. The facility manager interviewed stated that only the management team from the facility can access the site and the files are readily retrievable using a cataloguing system and was sighted.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| 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 | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The registered staff are able to show families around the facility and answer questions after hours and on weekends and an enquiry form is completed and followed up on the next working day by the management team. The nurse manager interviewed stated that she also visits the prospective resident while in hospital and speaks to the family and supporting health professionals prior to admission. The facility seeks updated information from the NASC, and/or GP for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB’s ‘pink envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example of a resident transferred to the local acute care facility showed appropriate communication and documentation. Family of the resident reported being kept well informed during the transfer of their relative. |
| 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 policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. The medication policy was last updated in May of 2017; however, needs further review to reflect current evidenced based practice. (Please refer to criterion 1.2.3.3). The prospective provider is experienced in the electronic system used at the facility and professional portfolio includes the set up and training of other facilities and their staff in this system.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart.  There were no residents self-administering medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by a qualified chef, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The chef has undertaken and updated safe food handling qualifications.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of three trained interRAI assessors on site. The prospective provider has interRAI training scheduled. Residents and families confirmed their involvement in the assessment process. Input is acknowledged by family/enduring power of attorney (EPOA) comment and signatures and indicated review of the residents’ care plans at regular intervals and/or when significant changes to care were required. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the specific and individual support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required is documented and care plans were sighted as working documents and information is verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their individual needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy, and volunteers.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.  Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. The facility received a continuous improvement rating in this area at the last audit. There continues to be a real focus and emphasis on supporting residents in continuing to socialise, interact, partake and to be involved and be part of the community and events that occur. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings and satisfaction surveys. Residents interviewed confirmed they find the programme very interactive and enjoyable. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Residents choose their own medical practitioners. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to the dietician, wound clinical nurse specialist, and geriatrician. The resident and the family/whānau are kept informed of the referral process, as was verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to the local hospital in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste, including recycling. Some discrepancies related to policies was sighted (Refer CAR 1.2.3.3). The storage of waste and chemicals in the sluice room, laundry, cleaners trolley and kitchen, was appropriate. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Waste, including the small amount of medical waste is removed from the facility by a contracted company  There is provision and availability of protective clothing and equipment and staff were observed using this. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | A current building warrant of fitness, expiry February 2018, is publicly displayed.  Audits occur to monitor the residents’ physical environment. The lounge, corridors and residents’ rooms are fit for their purpose. A sample of rooms visited showed that some repair work is needed to walls, as they are damaged. Corridor rails and doors have areas were the varnish requires redoing. Wooden cupboards and shelves have water damage. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with facility manager and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.  The prospective provider is seeking to increase the ‘swing bed’ numbers from two to seven. This would be done over time as they gauge the need for these number of hospital level beds. The purpose is to ensure that rest home residents can stay in their rooms if they progress to requiring hospital level care. The five rooms were reviewed (Rooms 5, 6, 7, 9, and 10). Work will need to be carried out to increase the size of the doors to these rooms which will involve the moving of some call bells and electrical points. All but one of the rooms has a hospital type bed and the additional one would be purchased. The rooms are of a size to allow staff and equipment use with the resident. The prospective provider would consider purchasing a second hoist for this area if the numbers required this. The present lounge in this area, known as the rest home lounge, is of a size which can accommodate an increase of residents with mobility aids and extra staff.  External areas are safely maintained and are appropriate to the resident groups and setting.  Staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of accessible showers and toilet facilities throughout the facility. This includes one room with a shower and toilet ensuite, eight rooms where two rooms share a toilet and shower, plus showers and toilets for other residents near to residents’ rooms and activity areas. Staff have their own separate toilet. Appropriately secured and approved handrails are provided in the toilet and shower areas, and other equipment such as a hoist, wheelchairs and walking aids are available to promote residents’ independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Rooms vary in size, however, adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms were observed to be personalised with furnishings, photos and other personal items displayed.  There is a cupboard used for the storage of wheel chairs. Staff and residents reported the adequacy of bedrooms. Resident and family satisfaction surveys showed a continued high level of satisfaction with the residents’ rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. Two dining and lounge areas are available and enable easy access for residents and staff. These were observed to be used by residents who found them appropriate for their needs. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents’ needs |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | An external laundry service is contracted to undertakes the majority of the laundry, towels and bedding. On site, a small dedicated laundry washes cleaning clothes and resident’s personnel laundry. Policies and procedures are not current to guide staff, see CAR 1.2.3.3. A system is in place to minimise the loss of resident’s garments. The cleaner/laundry staff member was able to demonstrate a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents and family members interviewed reported the laundry is managed well and their clothes are returned in a timely manner.  There is a small designated cleaning laundry team who have received appropriate training, as confirmed in interview of cleaning staff and training records. The resident care areas were observed to be clean and tidy. There are schedules for cleaning which staff follow. The sluice room and some cupboard areas were observed to be dusty and this was rectified during audit. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.  Cleaning and laundry processes are monitored through an internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are in place. Notices are displayed around evacuation and were known to staff. Emergency systems such as lighting and signage is part of the building warrant of fitness and are tested regularly. The facility manager provided evidence of disaster and civil defence planning. The current fire evacuation plan was approved by the New Zealand Fire Service in 2007. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in September. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, include torches, battery powered emergency lighting, food, water, blankets, mobile phones and gas BBQ’s were sighted and meet the requirements for the 30 residents. A large water storage tanks is located in the grounds.  Call bells alert staff to residents requiring assistance. Call bell audits are completed on a regular basis to ensure they are in working order. Residents and families reported staff respond promptly to call bells and this was observed during the audit.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and external lighting is available. Family members are asked to ring the facility before visiting in the evenings. No security incidents have been reported. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. All resident areas have natural light and opening external windows. Heating is provided by electrical heaters, in residents’ rooms and in the communal areas, with a replacement process underway which the prospective providers will continue. Resident and family satisfaction surveys indicated heating was an issue. The clinical nurse manager has documented that the residents were spoken with about this issue. She stated that the heaters in these residents’ rooms have now been upgraded. Areas were warm and well ventilated throughout the audit, with thermometers showing 20 degrees. Residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by an infection control manual, with input from an external source.  The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the nurse and quality managers, and tabled at the staff integrated and quality/risk committee meetings. This committee includes the management team, IPC coordinator, the health and safety officer, and representatives from food services, household management and care assistants.  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IPC coordinator has appropriate skills, knowledge and qualifications for the role, has been in this role for three months and is supported by the nurse manager and team leader. He has commenced training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in May 2017. Care delivery, cleaning, laundry and kitchen staff were observed following good safe practice, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves; however the practice of staff is not yet integrated to reflect the policy. (Please see criterion 1.2.3.3).  Hand washing and sanitiser dispensers are readily available around the facility. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather. Staff complete compulsory hand hygiene training yearly. |
| 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 | Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin infections and the upper and lower respiratory tract. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme and residents with infections are discussed. Graphs are produced that identify trends for the current year, and comparisons against previous years and information is shared with staff via regular staff integrated quality meetings and at staff handovers Data is benchmarked externally with other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standard 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 a sound understanding of the organisation’s policies, procedures and practice. There is a documented job description of this role which the co-ordinator has signed.  On the day of audit, eight residents were using restraints and two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. Two residents were interviewed in relation to their enabler use and stated an understanding of the process and where happy with the process used by staff.  Restraint is used as a last resort when all alternatives have been explored. There was evidence of residents undergoing a trial without their restraint or enabler as part of the ongoing review. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The annual restraint approval group meeting, is part of one of the RN meetings. The group is made up of the restraint co-ordinator, clinical nurse manager, nursing team leader, and the other RNs. There are terms of reference which detail those responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents’ files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored, analysed and there is a focus on restraint reduction.  Evidence of family involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint were documented and included all requirements of the standard. The RN undertakes the initial assessment, and the restraint part of the consent form is signed by the resident and family. The restraint coordinator described the documented process and five files were reviewed to confirm the completion of the assessment process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint and signs the consent form. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident’s safety and security and is documented in the resident’s care plan. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff, residents and family members. Examples of the use of low beds and sensor maps were sighted. Two residents with restraints are undertaking trials to reduce restraint use and this is documented in the care plan. When restraints are in use, half hourly monitoring occurs to ensure the resident remains safe and have their needs attended to. Records of monitoring had the necessary details, such as ‘on-off’, toileting and food and fluids.  A restraint register is maintained, updated and reviewed at each restraint approval group meeting. The register was reviewed, with the restraint co-ordinator, and contained all residents currently using a restraint and sufficient information to provide an auditable record.  Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Review of five residents’ files showed that the individual use of restraints is reviewed three monthly as part of the care plan and interRAI reviews. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.  The evaluation covers all requirements of the standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint committee undertakes an annual review of all restraint use which includes all the requirements of this Standard. Restraint is part of the internal audit process and review of the monthly audits show compliance to the organisational policy and procedure. The restraint compliance and competency audit report showed evidence of review of the use of restraints. Corrective actions have included additional education for staff, and this was confirmed by the restraint co-ordinator.  The restraint co-ordinator discussed, and the data showed, that the use of restraint is generally trending down, but is very dependent on the residents present in the facility. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | There is evidence that the content of the six policy manuals are reviewed two yearly and signed off by the relevant manager. The health and safety policy does not reference the new legislation and the facility manager was not aware of some of the changes from that legislation. From review of the medication and pressure injury policies, it was evident the policies have been reviewed and added to; however, the areas which had been superseded had not been removed from the documents.  An external contractor’s infection control policy manual has been implemented; however, the polices do not contain the level of detail which make the policies relevant to this particular organisation.  The cleaning and laundry staff member interviewed provided evidence of her work practices, some of which were not documented, for example, the management of body fluid spillage. A folder, used by these staff, contained policies whose footer identified that it was overdue for review. The quality co-ordinator stated these were not the up-to-date policies. A chemical use guidance chart, did not contain all the chemicals used. | The facility manager and quality co-ordinator were not aware of aspect related to changes to legislation and this is not reflected in the policy related to health and safety.  There are multiple documents used to guide cleaners and laundry staff in their work. Some of the policies sighted differ from the organisational policy manual documents and are past their review date. Chemical use charts do not contain all the chemicals being used. Staff do not have documented policy on the body spills procedure.  Infection control policies are yet to be integrated into the organisational requirements.  There are medication and pressure injury policies which have been superseded, but not removed from the folder, and could lead to confusion for staff. | The health and safety policies be reviewed to ensure they meet the requirements of the new legislation.  Cleaning and laundry staff have clear documentation to guide their practices.  Infection control policies be reviewed to ensure they detail the organisational specific requirements.  Medication and pressure injury policies are reviewed to ensure the evidence which is no longer relevant is removed.  90 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | The building and equipment meets the requirements of legislation. There is a ‘handyman’ who comes daily and undertakes repairs, maintenance requirements identified by staff and audit activity, such as hot water temperature monitoring. Environmental review showed that the facility is fit for purpose and there is ongoing maintenance, such as removal of carpet from rooms and new vinyl being laid. A sample of rooms and the sluice room showed that the integrity of the walls in areas where the bed butts up against the wall has been compromised and requires repair. Some wooden cupboards and shelves have water damage and are in need of repair. The wooden doors and corridor handrails are varnished and the integrity of these in a number of areas is compromised and needs redoing. | In a sample of rooms visited, and the sluice room, it was observed that the walls have damaged plaster and are in need of repair and painting. There are doors and walls where the integrity of the paint/varnish is compromised. Cupboards were seen which have water damage and are in need of repair and painting or replacement. | The integrity of walls, doors, cupboards and surfaces is intact to ensure good infection control is possible.  180 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

|  |
| --- |
| No data to display |

End of the report.