Albany Rest Home 2004 Limited - Albany House

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Albany Rest Home 2004 Limited
Premises audited:	Albany House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 February 2019 End date: 20 February 2019

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 23

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Albany House is certified to provide rest home and hospital level care for up to 25 residents. On the day of audit there were 23 residents.

The nurse manager/owner is actively involved in the running of the facility. The nurse manager is supported by an enrolled nurse (administrator) and a team of registered nurses and care staff.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

Residents and family/whānau interviewed commented positively on the standard of care and services provided at Albany House.

The service has addressed one of three findings from the previous certification audit around service provision timeframes. Further improvements are required in relation to the quality and service delivery.

This audit also identified that improvements are required around staff education and aspects of medication management.

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.

There is a policy to guide staff on the process around open disclosure. Residents and families are welcomed on entry, information is provided and explained about the services and procedures. Regular contact is maintained with family, including if an accident/incident or a change in resident's health status occurs. There is a complaints policy to guide practice which aligns with Right 10 of the Code. A complaints procedure is provided to residents within the information pack at entry. Complaints reviewed in 2017 and 2018 reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Albany House is implementing a quality and risk management system that supports the provision of clinical care. Quality and risk data is collated for residents' falls, infection rates, complaints received, restraint use, pressure injuries and medication errors. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice.

There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements.

Continuum of service delivery

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

The registered nurses are responsible for each stage of service provision. A registered nurse completes initial assessments, risk assessments, interRAI assessments and long-term care plans within the required timeframes. Care plans are evaluated at least six monthly and meet the resident's current needs and supports.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed met prescribing requirements and were reviewed at least three monthly.

Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

There is a current building warrant of fitness. Fire evacuations have been undertaken six monthly.

There are documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building has a current warrant of fitness.

Restraint minimisation and safe practice

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

The organisation actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There were two residents using enablers and no residents using restraint.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	12	0	1	3	0	0
Criteria	0	36	0	1	4	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints. Complaints are being managed in a timely manner, meeting the requirements determined by the Health and Disability Commissioner (HDC). Five complaints were lodged in 2018 and five in 2017 including one lodged with the Health and Disability commissioner. The HDC complaint lodged in August 2018 remains open. The service has complied with all requests for information. There have been no complaints lodged in 2019 (year to date). Evidence of acknowledgement, an investigation and outcomes were documented for all complaints reviewed. All complaints were documented as resolved. Albany House documents all resident concerns and suggestions for improvement through the complaints system. Corrective actions have been implemented and any changes required were made as a result of a lodged complaint (where indicated). The complaints process is linked to the quality and risk management system. Evidence of complaints being discussed in management and staff meetings was sighted in meeting minutes.
Standard 1.1.9:	FA	An open disclosure policy describes ways that information is provided to residents and families. The

Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		manager welcomes residents and families on entry and explains about services and procedures. Six residents (five rest home and one hospital) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. Evidence of communication with family/whānau is recorded on the accident/incident form and in the residents' progress notes. Accident/incident forms reviewed identified family had been kept informed. One relative (hospital) interviewed, stated that they were informed when their family member's health status changed. Interpreter services are available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Albany House is an independently owned service that provides rest home and hospital level care for up to 25 residents. On the day of audit, there were 23 residents (14 rest home and nine hospital residents). Of the fourteen hospital residents, two residents were on a long-term chronic health contract. The facility has twenty dual-purpose beds which can be used for the provision of rest home or hospital level care. The nurse/manager (owner) is on site Monday – Friday and can be contacted to support staff after hours. The nurse manager is supported by an enrolled nurse, who performs an administration role, care staff and registered nurses. The goals and direction of the service are documented in the business plan and the plan is reviewed annually. The nurse manager has completed eight hours annually of professional development activities related to managing an aged care residential facility.
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 Moderate	Albany House has policies/procedures to support service delivery which have been provided by an external consultant. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly and updated externally. The business plan includes a quality and risk management plan that describes objectives, management controls and assigned responsibility. The business plan is reviewed each year and objectives updated. Combined quality, health and safety, infection control and full staff meetings have been held, however not three monthly as scheduled. Minutes for these meetings held include actions to achieve compliance where relevant. Management and staff advise quality improvement data is discussed at the quality/staff, however meeting minutes do not reflect this. The previous partial attainment continues to require addressing. Data is collected on complaints, accidents, incidents, infection control and restraint use. The owner manager (RN) facilitates the quality programme and ensures the internal audit schedules are implemented. Areas of non-compliance identified through quality activities are actioned for improvement. Resident surveys have been completed in 2017 and 2018, however there is no evidence of correlation, trending or sharing of

		information with residents, families or staff. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. There is a designated health and safety officer. Health and safety issues are discussed at quality improvement/staff meetings with action plans documented to address issues raised. Resident/relative meetings have been held, however not at the scheduled frequency. Two resident meetings were held in 2018. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.
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	The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Twelve incidents (all incidents from January 2019) demonstrated appropriate documentation and clinical follow-up. Accidents and incidents are collated monthly. The management team are aware of situations that require statutory reporting. No events have required reporting.
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.	PA Low	Five staff files sampled (a registered nurse, the cook, the activities coordinator and two caregivers) show appropriate employment practices are documented. Current annual practising certificates are kept on file. The orientation package provides information and skills around working with residents with rest home and hospital level care needs and were completed in all staff files sampled. There is an annual training plan in place and implemented. All staff files reviewed for staff who have been employed for more than 12 months contain a current annual performance appraisal. Residents stated that staff are knowledgeable and skilled. An education plan is documented as part of the quality system. At least eight hours is offered annually, however not all mandatory training has been provided.

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 rationale for staffing the service. The nurse manager (owner) works Monday – Friday and provides on-call after hours support to the staff. The enrolled nurse (administrator) holds a current practising certificate, works three days a week, and provides support to staff and the nurse manager. On the day of audit there were 23 residents consisting of 9 hospital and 14 rest home level care residents. There is a registered nurse on every shift. The RN is supported by one full shift and two short shift HCAs on the AM shift. For the PM shift, there is one long shift and one short shift HCA. There is one HCA supporting the RN on night shift. An activities officer provides activities for two hours a day, five days a week. A review of two weeks rosters, observation of staffing levels, monitoring of call bell response times on the days of audit, interview with family, residents and staff confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time.
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.	PA Moderate	The medicine management policies and procedures meet guidelines and current legislative requirements. In interview, the nurse manager reported that prescribed medications were delivered to the facility and checked on entry by the registered nurse. Medications are stored securely. The controlled drug register was maintained, however weekly stocktakes were not always completed as scheduled. Six monthly physical stocktakes were being implemented. All medication was safely stored, however on the day of audit, not all eye drops in use were dated or had current dates. Medications that are required to be stored in a refrigerator are placed in a sealed plastic container inside the main kitchen fridge. The fridge temperatures were conducted and recorded. Staff authorised to administer medicines had current competencies. The medication round was observed and evidenced the staff member administered and signed off, as the dose was administered. Administration records were maintained, as were specimen signatures. Staff education in medicine management has been provided in the past 12 months for all staff. Medication charts are written by the GP and there was documented evidence of three-monthly reviews. Medications reviewed were prescribed and charted in line with guidelines. There were no residents self-administering on the day of audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual	FA	There is a fully functional kitchen and all food is cooked on site by experienced kitchen staff. A food control plan has been verified and expires in March 2019. There is a food-services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review and updates provided to the kitchen. The kitchen is able to meet the needs of residents who require special diets and the head cook

food, fluids and nutritional needs are met where this service is a component of service delivery.		works closely with the RNs on duty. The kitchen staff have completed food safety training. The cooks follow a rotating seasonal menu, which has been reviewed by a dietitian in March 2017. The dietitian has been contacted to undertake a bi-annual menu review. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. The cook interviewed was familiar with each individual resident's requirements, likes and dislikes. Residents and the family members interviewed were very happy with the quality and variety of food served and confirmed they were offered alternatives if requested.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	The registered nurse and healthcare assistants follow the care plan and report progress against the plan at least daily or more frequently if needed. If external medical advice is required, this will be actioned by the GP. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, physiotherapist and speech language therapist). Staff reported they have access to sufficient continence products and resident files include a continence assessment and plan. Staff have access to sufficient medical supplies (eg, dressings). There were two documented wounds at the time of audit including one chronic ulcer and a stage two pressure injury. Wound care is undertaken by the registered nurses. A review of the process, practice and documentation of wound care evidences wounds are assessed, dressed and evaluated according to the documented management plan. Interviews with the registered nurse and healthcare assistants demonstrated an understanding of the residents in their care. Monitoring charts are available, including blood sugar monitoring forms with acceptable ranges documented, and registered nurses interviewed could describe when these have been used. Weights, observations, food and fluid charts and blood sugar monitoring were completed as per care plan interventions. Residents with weight loss were identified. Effectiveness of pain medications was not always documented and not all interventions were in sufficient detail to guide staff on safe restraint/enabler use. The previous partial attainment continues to require addressing. The registered nurses interviewed could describe access to specialist services if required.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are	FA	The activity coordinator was on leave on the day of audit and the nurse manager provided an overview of the programme. The service provides an activities programme for ten hours a week (Monday to Friday) with the flexibility to increase hours for outings as required. The activities coordinator has been in the role for two years and provides a programme designed to meet the individual resident's needs. Regular entertainers visit the home and there are links to a local school and community to involve them in activities with the residents. There are regular outings into the community. There is a range of activities to

appropriate to their needs, age, culture, and the setting of the service.		meet the recreational preferences and individual abilities of the residents. One-on-one time is spent with residents who choose not to participate in the group programme. The activities coordinator completes a resident social profile and activities assessment on admission. Each resident has an individualised activity plan which is reviewed six monthly. Residents and family interviewed commented the regular activity programme provides an interesting and enjoyable programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate all initial care plans within three weeks of admission. There is at least a three-monthly review by the GP. An RN signs care plan reviews. Files evidenced that changes had been initiated to the care plan in response to changes in health needs or where progress was different from expected. Changes in short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files sampled. Staff advise that in most cases, changes are made directly to the long-term care plan and reviewed six monthly or sooner when required.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Albany house is a single storey building. Fixtures and fittings are appropriate and meet the needs of the residents. There is a current building warrant of fitness which expires in June 2019. The outside areas are landscaped, with pathways and garden beds. Hot water temperatures are monitored by the maintenance person. There is a documented preventative and reactive maintenance programme. A maintenance person is employed to attend to all maintenance and repairs. Preventative and reactive maintenance issues are addressed.
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	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and compared month by month. Outcomes and actions are not evidenced as discussed at staff meetings (link 1.2.3.6). If there is an emergent issue, it is acted upon in a timely manner. The infection rate is very low and there have been no outbreaks.
Standard 2.1.1: Restraint minimisation	FA	The policy identifies that restraint is used as a last resort. The nurse manager and care staff are aware that enablers are to be used voluntarily. Two hospital level care residents use bed rails to assist with repositioning when in bed. The care plan reviewed documented the use of the enabler, however did not

Services demonstrate that the use of restraint is actively minimised.		include the risks associated with their use (link 1.3.6.1). Staff have been trained in the management of behaviours that challenge and restraint and enabler use.

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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	There is a scheduled quarterly quality improvement/staff meeting to which all staff are invited, however meetings have not always occurred as scheduled. Aspects of the quality programme include (but are not limited to): complaints, health and safety, accidents and incidents, internal audit outcomes, and infections, however meeting minutes do not evidence discussion about quality indicators. Resident meetings are held. Small resident and staff numbers and open discussion means issues are discussed with management as they arise. Corrective actions are implemented in response to internal audit shortfalls.	i) Combined quality improvement and staff and resident meetings are scheduled quarterly, however both have occurred only twice in 2018. ii) Meeting minutes do not reflect evidence of discussion of quality trends and corrective actions. iii) Annual resident	i) Ensure quality improvement/staff and resident meetings are held as scheduled. ii) Ensure staff meeting minutes evidence discussion of quality indicators and improvement data. iii) Ensure resident surveys are corelated, analysed and the results are

			surveys completed in 2018 have not been correlated, analysed or discussed with staff, family or residents.	communicated to staff, residents and family. 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	An education plan is documented as part of the quality system. At least eight hours is offered annually, however not all mandatory training has been provided.	Not all required education has been provided as per contractual requirements. Staff have not received training in abuse and neglect, pain management, and chemical safety.	Ensure education planning includes all required education as per contractual requirements and resident current needs. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	All medications are securely stored in a locked cupboard. Medication is regularly reviewed for expiry dates by a registered nurse, however not all eyedrops in current use evidenced current expiry dates. Medications are administered by medication competent staff who receive annual training.	Two of four eye drops in current use did not evidence opening dates and two of four eye drops were in continued use past their expiry date.	Ensure all eyedrops are dated on opening and not used past expiry dates. 30 days
Criterion 1.3.12.6	PA	Medication charts reviewed identified that controlled drugs were appropriately prescribed. Signing charts and the controlled	The controlled medication	Ensure that the controlled

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	Moderate	medication register documented two staff always sign for medication. There have been no weekly checks of the controlled drug register.	register had not been stock checked weekly.	medication register has a documented weekly stock check. 30 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Four of five long-term care plans evidenced that interventions were updated following a change in resident need identified during the evaluation process. However, not all interventions were documented in care plans.	i) One long-term care plan for a hospital resident did not include interventions for safe enabler use. ii) One long-term resident using 'as required' analgesia did not document efficacy.	i) Ensure care plans include interventions for the safe use of enablers and or restraint. ii) Ensure effectiveness of 'as required' pain relief is documented. 60 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.