Oxford Court Lifecare Limited - Oxford Court Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Oxford Court Lifecare Limited
Premises audited:	Oxford Court Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 February 2019 End date: 22 February 2019

Proposed changes to current services (if any): The addition of a new 22 bed wing to the current facility (dual purpose beds with one room being a double room). This increases bed numbers from 50 to 72 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 48

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

Oxford Court Lifecare is certified to provide hospital (geriatric and medical) and rest home level care for up to 50 residents. On the day of audit there were 48 residents.

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

A concurrent partial provisional audit was also conducted to verify the addition of a new 22 bed wing which is attached to the current facility. The new wing includes 21 dual purpose rooms including one double room. This will increase the total bed numbers from 50 to 72. This audit has verified the new wing as suitable to provide rest home and/or hospital level care.

The facility is managed by an experienced registered nurse who has been in the role for seven months. She is supported by a clinical manager (registered nurse) who has been in the role for 5 years. The facility manager reports monthly to the facility owners, who visit the facility at least monthly.

This certification audit has identified no areas for improvement. The partial provisional identified areas for improvement related to the completion of the building, call bell installation and fire evacuation plan.

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.

Oxford Court Lifecare seeks to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. There is a Māori health plan and cultural safety policies that guide staff in cultural safety, including recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. There are policies and procedures which reflect key relationships, beliefs, cultures, personalities, skills and life experiences are acknowledged. Oxford Court promotes and encourages good practice. There is evidence that residents and family are kept informed. A system for managing complaints is in place, and a complaints register is maintained.

Organisational management

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

Oxford Court Lifecare has a business plan and quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme including hazard management. Aspects of quality information are reported to monthly combined quality/infection control/health and safety meetings, staff meetings, and registered nurse/clinical meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at regular resident meetings and via satisfaction surveys. There is a reporting process in place to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Oxford Court has comprehensive job descriptions for all positions. There is an annual in-service training programme and staff are

supported to undertake external training. The service has a documented rationale for determining staffing levels and residents and family members report staffing levels are sufficient to meet resident needs.

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 low risk.

Entry to the service is managed primarily by the care manager and registered nurses. There is comprehensive service information available. Assessments, care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans are written in a way that enables all staff to clearly follow their instructions. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

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.		Some standards applicable to this service partially attained and of low risk.

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy, and all have their own toilets with most having full ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and laundry staff are providing appropriate services.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Partial Provisional: A new dual-purpose wing with 21 rooms including one double room, has been built adjacent, and connected to the existing building. Resident bedrooms are large with individual heat pumps in each room. The unit includes a large communal area with external access to a sheltered courtyard deck.

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.

There is a restraint policy that includes restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently no residents using restraint or who have requested the use of an enabler. Staff are trained in restraint minimisation and challenging behaviour management.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented. It meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	42	0	3	0	0	0
Criteria	0	89	0	4	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. Families and residents have been provided with information on admission which includes the Code. Interviews with staff (six caregivers, five registered nurses, one CAP student, one diversional therapist, one facility manager and one clinical manager) confirmed their familiarity with the Code, and confirmed they respect privacy and support residents in making choices where appropriate. Interviews with seven residents (two rest home and five hospital) and six relatives (one rest home and five from the hospital) confirmed that the services provided are in line with the Code. The Code is discussed at resident and staff and various facility meetings.
Standard 1.1.10: Informed Consent Consumers and where appropriate their	FA	Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. There was evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the

family/whānau of choice are provided with the information they need to make informed choices and give informed consent.		service actively involves them in decisions that affect their relative's lives. Seven of seven resident files sampled (one from the rest home, six from the hospital including one on a long term chronic health contract) had a signed admission agreement and consents
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There is a policy that describes access to advocacy services. Information about accessing advocacy services information is available in the reception area. This includes advocacy contact details. The information pack provided to residents provides residents and family/whānau with advocacy information. The complaints process also includes informing the complainant of their right to contact the Health and Disability Advocacy Service. An advocate support person attends at least two resident meetings per year, and is available on request. Interview with staff, residents and relatives' evidences that they are aware of advocacy and how to access an advocate. Staff receive training on advocacy.
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	Entertainers, volunteers and priests provide links with the community. There are several visiting professionals contracted by the service that provide links. Residents' are encouraged to be involved in community activities and maintain networks with family and friends. Care staff reported that residents are encouraged to build and maintain relationships. Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. All residents are encouraged to maintain their independence and links to the community. Activities programmes include opportunities to attend events outside of the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Oxford Court has a complaints policy and complaints process. There are complaint forms available at the entrance. Information about complaints is provided on admission. There is a complaint register. There were nine complaints December 2017 to date. No trends were identified. Verbal and written complaints are documented. All complaints have documented: investigation, timelines, corrective actions when required and resolutions. Results are fed back to complainants. Staff confirmed that complaints are discussed with them at staff meetings, and they notify RNs and/or the management if any residents and family members want to make a complaint. In relation to the DHB complaint around meals and lack of heating in a bedroom. There has been a food satisfaction survey completed in January 2019, which had ten responses with overall satisfaction, four residents had suggestions for improvement, which has been acted on. Food is available in the kitchen 24/7, kitchen staff plate the meals, HCAs serving request larger or smaller portions depending on the resident request. There are alternatives available and the cook often talks with the residents. The food service is being

		outsourced to an external provider. Residents stated the food was “overall fine”. On the day of the audit, the room temperatures were comfortable in the existing building with underfloor heating, there are panels in the corridor for staff to adjust if required, environment temperatures are checked six monthly. In the new wing, there is a heat pump/ air conditioner in each residents’ room, the main control panel for all the heat pumps is in the new nurse’s station. These can be adjusted accordingly to the resident’s heating/cooling preferences. Interview with residents and relatives demonstrated an understanding of the complaints process.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There are posters of the Code on display throughout the facility and leaflets are available in the reception area of the facility. The service can provide information in different languages and/or in large print if requested. The admission agreement includes information around the scope of services, and any liability for payment for items not included in the scope and the Code. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service a registered nurse (RN) or the clinical manager discusses the information pack with the resident and the family/whānau. Resident meetings provide the opportunity to raise issues/concerns.
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	The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. The staff were observed to respect residents’ privacy and dignity by closing doors when carrying out personal care. Residents were observed to have call bells placed within reach when left unattended in their room. Residents with shared bathrooms have a privacy lock. Residents interviewed reported that staff respected their privacy and dignity when carrying out personal care. Staff described how they manage maintaining privacy and respect of personal property. Residents are encouraged to maintain their independence. Outings are encouraged and supported for the residents who are able. Staff interviewed stated that they encourage the residents' independence by encouraging them to be as active as possible. There is a policy that describes spiritual care. Church services are conducted in the facility on a monthly basis. Seven resident files reviewed identified that cultural and/or spiritual values and individual preferences were identified on admission with family involvement and these were documented in the residents' care plan. This includes cultural, religious, social and ethnic needs. All residents and relatives interviewed indicated that residents’ spiritual needs are being met when required. Staff are familiar with the policies and appropriate practices around the prevention and identification of abuse

		and neglect. Training has been provided.
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	Oxford Court has a Māori health plan which refers to the Te Whare Tapa Whā model of care. There are policies that guide staff in cultural safety. Staff training includes cultural safety. The service can access Māori advisors as identified in the Māori health plan and policies. Where residents identify as Māori; specific service and cultural needs are addressed in their care plan. Cultural and spiritual practice is supported, and identified needs are incorporated into the care planning process and review. Interviews with staff confirmed that they are aware of the need to respond to cultural differences. Cultural diversity is a focus in the quality plan for 2019.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service has established cultural policies aimed at meeting the cultural needs of its residents. All residents and relatives interviewed reported that they are satisfied that their cultural and individual values are being met. The residents' personal needs and values were identified on admission and this information was gathered from previous interRAI assessments and residents, family and/or EPOA. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff received education on cultural safety, values and beliefs in August 2018.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Oxford Court has a staff code of conduct (house rules), which states there will be zero tolerance against any discrimination. The clinical manager and registered nurses supervise staff to ensure professional practice is maintained. The abuse and neglect policy covers harassment and exploitation. All residents interviewed reported that the staff are respectful and considerate. The facility manager, clinical manager, nurses and care workers interviewed, demonstrated a clear understanding of professional boundaries. Documented job descriptions describe the functions and limitations of each position. The orientation and employee agreement provided to staff on induction includes standards of conduct.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There are comprehensive policies and procedures that align with the Health and Disability Services Standards to meet the needs of residents requiring rest home and hospital level of care. Staffing policies include pre-employment checking and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects overall satisfaction with the services that are provided. Residents and relatives speak very positively about the care and support provided. Staff interviewed have a sound understanding of principles of aged care and stated that they feel supported by the management team. There is a staff training programme which covers all aspects of service delivery. Internal auditing programmes are implemented. External specialists such as the wound care specialist, nurse practitioner, and continence nurse were used where appropriate. The clinical meetings show improvements in clinical care. There is ongoing staff training with a focus on increasing Careerforce training in 2019.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Seventeen incident reports from February 2019 were viewed. All forms indicated family have been informed or if family did not wish to be informed. Relatives interviewed reported that they are notified of any changes in their family member's health status. Interviews with six caregivers, and five RNs informed that family are appropriately notified following a resident change in health status. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. There was also evidence of family input into the care planning process and interRAI assessments. The facility has an interpreter policy to guide staff in accessing interpreter services. There are no residents who currently require an interpreter. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.
Standard 1.2.1: Governance The governing body of the	FA	Oxford Court Lifecare changed ownership in May 2017. This was a transfer of shares only. The facility currently has 50 beds; on the day of the audit there were 48 residents. There were eight residents at rest home level, and 40 residents at hospital level care including three residents on a Long-Term Support- Chronic

organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		Health Contract (LTS-CHC). All 50 rooms are dual-purpose to accommodate hospital or rest home level of care residents. The facility has a business, quality and risk management plan which has specific annual quality goals identified that link to the business plan and are reviewed quarterly. The facility manager is an experienced registered nurse, and has been in the role for seven months, and holds a post graduate certificate in gerontology. A clinical manager (RN) has been in the role for five years, and supports the facility manager. There are job descriptions for both positions that include responsibilities and accountabilities. The facility manager advised that the owners visit at least monthly and are available to be contacted by email or telephone at any time. A monthly management report is completed by the facility manager and forwarded to the owners. The manager and clinical manager maintain at least eight hours annually of professional development activities related to managing an aged care facility, including a leadership and management course, a training and supervision workshop and an ACC seminar. A partial provisional was included as part of this audit to verify the addition of a new building (22-bed unit) as suitable to provide both rest home and hospital level care. The new unit was verified as suitable to provide dual-purpose care. There is no date set to open, as there was still work to be completed. All equipment has been purchased, all beds are electric four stage beds, with seven low beds. Three hoists (two full body and one standing) had been purchased and were in storage. Chairs were in place in the bedrooms, overbed tables had been ordered. Furniture from the existing lounge will move into the new lounge. A planned roster has been developed showing staffing levels as the occupancy rises.
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	In the absence of the facility manager the clinical manager is in charge with support from the owners and care staff. Partial Provisional: The clinical manager will continue to stand in for the facility manager with the increase of the 22-bed unit. There is also additional support from the owners should the need arise.
Standard 1.2.3: Quality	FA	The quality programme includes the service philosophy, general objectives and lists the quality activities. An

And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		annual quality plan for 2019 has been developed and is being implemented. An internal audit schedule is in place. Corrective actions have been developed where compliance is less than expected. Discussion of quality data is documented in the meeting minutes reviewed for staff, combined quality/health and safety/infection control, RN/clinical and resident meetings. Resident and relatives' meetings are held with follow-up of issues and discussions documented. Interviews with the facility manager, clinical manager, RNs and caregivers confirmed that the quality programme is implemented, and results are communicated to staff and relevant people. There is a document control policy and all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. Resident surveys are conducted six monthly, the relative survey was last conducted in October 2018 with respondents advising that they are overall very satisfied with the care that they receive. Issues identified in the survey have been addressed with corrective actions implemented. The manager is the health and safety officer who has attended training in health and safety. The health and safety committee is made up of a staff representative from all departments. Oxford Court collects information on resident incidents and accidents as well as staff incidents/accidents, and provides follow-up where required. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Health and safety is included in the annual competencies which staff complete, and is part of the orientation of new staff. Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been reviewed bi-annually, and was last updated in May 2017. The hazards register includes all hazards associated with the new building. Security and safety policies and procedures are in place to ensure a safe environment is provided.
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	There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the clinical manager and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff meetings, health and safety/IC/quality meetings and RN/clinical meetings, including actions to minimise recurrence. Fourteen incident forms (eleven hospital and three rest home) sampled from February 2019 document clinical follow-up of residents is conducted by a registered nurse. Incident forms have a section to indicate if family have been informed (or not) of an incident/accident, and these were fully completed, and the reason was documented if the notification did not occur. Interviews with the facility manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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	There are human resource management policies in place which include that relevant staff checks are completed to validate the individual's qualifications, experience and veracity. There are comprehensive human resources policies including recruitment, selection, orientation, staff training and development to guide management to ensure that appropriate people are recruited to vacant positions. Eight staff files reviewed (one clinical manager, one RN, two DTs, one cook and eight caregivers (four from each area). All had relevant documentation relating to employment, and relevant checks were completed to validate individual qualifications and experience. All had annual performance appraisals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There is an education plan that is being implemented that covers all contractual education topics, and exceeds eight hours annually. The clinical manager and registered nurses can attend external training including sessions provided by the local DHB. A competency programme is in place that includes annual medication competency for staff administering medications. There is a minimum of one staff member with a current first aid certificate on every shift. A record of practising certificates is maintained. There are eight RNs and one enrolled nurse employed at Oxford Court, five RNs are interRAI trained, another RN is in training. The enrolled nurse is interRAI trained. Interviews with the facility manager reported there has been a slow uptake of Careerforce training. There is currently one caregiver completing level two, and one completing level three. Two caregivers have completed level two, two have completed level three. Partial provisional: There is a planned draft roster of planned staffing levels as occupancy increases, in step one, the facility will have adequate staffing to cover new admissions to the new wing until five residents are admitted.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Policies include staff rationale and skill mix. Sufficient staff are rostered on duty to manage the care requirements of the residents. The facility and clinical manager (RN) both work full-time. In the Reid wing, (22 hospital level residents, three rest home level) there is an RN or EN rostered on duty on morning and afternoon shift seven days a week. In the Maher wing, (20 hospital level, and five rest home) there is a registered nurse rostered on all shifts. The RN rostered on night duty covers both wings. Each wing has four healthcare assistants each morning shift, three long shifts (7.00 am-2.00 pm, 6.45 am-3.00 pm, 8.30 am-4.00 pm in Maher, and 6.45 am-3.00 pm, 7.00 am-2.30 pm and 7.00 am-2.00 pm in Reid), and one short shift (7.00 am-1.30 pm in both wings).

		The afternoon has two long shifts in Maher (2.30 pm-11.00 pm, 3.30 pm-9.30 pm) in Reid has three long shifts (2.30 pm-11.00 pm, 3.30 pm-10.00pm, 4.00 pm-9.30 pm) and one short shift (4.30 pm-9.00 pm in Maher). At night, there are three healthcare assistants (one floats between each wing). The clinical manager (registered nurse) works full time Monday – Friday. The facility manager is also a registered nurse and works full time Monday – Friday. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. Partial provisional: There is a draft roster for each stage of the admission process in the new wing. There is a draft roster also for when the Caradus wing is fully occupied. This includes three HCA morning working long shifts (6.45 am-3.00 pm, 7.00 am-2.30 pm, 7.00 am-2.00 pm) and three healthcare assistants in the afternoons, two working long shifts (2.30 pm-11.00 pm, 3.00 pm-10.00 pm) and one short shift (4.30 pm-9.30 pm). One registered nurse is rostered for overnight alongside the existing staff. Provision of activities will be extended as new residents arrive. The laundry hours will be increased as new admissions are admitted into the new wing up to seven hours a day (9.00 am - 4.30 pm) and a new cleaner will be employed for four hours a day (10.00 am - 2.00 pm).
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All relevant initial information was recorded within required timeframes into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are electronic. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration, including records from allied health professionals and specialists involved in the care of the resident. Information in the electronic medication management system and interRAI data are password protected.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The manager and the care manager screen all potential residents prior to entry and record all admission enquiries. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

for services has been identified.		
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.
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 Low	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed was signed as administered on the electronic medication management system. Registered nurses administer medicines. All staff that administer medication are competent and have received medication management training. The facility uses a robotics pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. The 14 medication charts sampled were documented correctly by medical practitioners and there was evidence of three monthly reviews by the GP. There were four residents self-administering medicines. Partial Provisional: All staff involved in medication administration are trained and complete an annual competency. There is a dedicated room for secure and safe storage of medication in the new wing, however this was not fully fitted out, and did not have locks on the day of audit.
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	There is a fully functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. There is a food control plan implemented with an expiry of June 2019. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the kitchen manager works closely with the RNs on duty. The kitchen cooks have completed food safety training. The cooks follow a rotating seasonal menu, which has been reviewed by a dietitian. This is due for renewal and a new menu has been approved by the dietitian for the contract company starting in two weeks' time. 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. Residents and the family members interviewed were very happy with the quality and variety of food served.

		Partial Provisional: There is an existing kitchen with a servery to a large adjacent dining room. The kitchen has recently been extended to include more bench space, a walk-in chiller and a double stack combi oven and a new gas oven and stove. Services will be contracted to a food services company from March. The manager advises that the company will work very closely with the facility to provide food that is suitable for resident needs and can cater for all types of diet.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments reviewed were completed and were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. Care plans reviewed were developed on the basis of these assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. Residents and their family/whānau are involved in the care planning and review process. Short-term care plans are in use for changes in health status on a particular section of the electronic care plan. Staff interviewed, reported they found the plans easy to follow.
Standard 1.3.6: Service	FA	Registered nurses (RNs), the enrolled nurse, the care manager and healthcare assistants follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required the

Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		RNs will initiate a referral (eg, to the hospice nurse or wound care nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management plans were in place for three residents with eight wounds (one surgical, one ulcer and six skin tears) and one stage two pressure injury (facility acquired). Documentation was fully completed. The RNs have access to specialist nursing wound care management advice through the district nursing service. Care plan interventions including repositioning and food and fluid charts, demonstrate interventions to meet 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	A diversional therapist and an activities coordinator are both employed for 28 hours per week and between them cover Monday to Saturday 9.45 am to 5.00 pm. The activities team provide a varied programme designed to meet the needs of the rest home and hospital residents. Each resident has an individual activities assessment on admission, and from this information an individual activities plan is developed as part of the care plan by the diversional therapist. Each resident is free to choose whether they wish to participate in the group activities programme, or their individual plan, and significant time is dedicated to 1:1 activities. Participation is recorded in the attendance register. Group activities reflect ordinary patterns of life and include planned visits to the community. Community activities include visits from the blind foundation and aged concern. An interdenominational church service is held monthly. Entertainers are scheduled twice monthly. Residents and relatives interviewed spoke positively about the activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	In files sampled all initial care plans were evaluated by the registered nurses within three weeks of admission. The long-term care plans reviewed were evaluated at least six monthly or earlier if there was a change in health status. There is at least a three-monthly review by the GP. All changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.

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	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident electronic files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in multi-disciplinary meetings and medical notes. The staff provided examples of where a resident's condition had changed, and the resident was reassessed.
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	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available. Partial Provisional: The current processes around the management of waste and hazardous substances are continued in the new unit. There is a sluice room which is not fully fitted out (link 1.4.2.1). There is a lockable housekeeping cupboard.
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	The existing building has a current building warrant of fitness. There is a maintenance person employed two days a week to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. Partial Provisional: The new dual-purpose wing is attached to the existing building through two connecting doors. The internal door from the main dining room into the lounge area of the new wing is accessed by a double door at the end of a ramp, with a balustrade. The current lounge/dining room adjacent to the kitchen will be expanded to meet the needs of all residents as the main dining room. The new lounge is light and

		spacious enough for the proposed 22 residents and the 24 residents from the existing downstairs wing. The existing kitchen has recently been extended and is large enough to accommodate the additional 22 residents. The new wing surrounds a central courtyard style deck with built-in seating and includes a reception area, managers office, nurses' station, medications room and sluice room. The resident rooms are large and equipped with air conditioning and a wall mounted television. Handrails have been installed in the hallways and bathrooms. Garden plans include a large tree to be planted in the middle of the courtyard deck and planting along the back wall. A covered scooter bay is under construction at one end of the back wall. The new wing was observed to be almost finished, a certificate of public use is yet to be obtained.
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 toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Most bedrooms have their own ensuites and some have shared ensuites. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. Partial Provisional: Each resident room has toilet and wet floor shower facilities of an appropriate design to meet the needs of the residents. There are communal toilets located near the lounge/dining rooms. Communal toilet facilities have a system that indicates if it is engaged or vacant.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids including those required by hospital level care residents in the dual-purpose and hospital level rooms. Residents are encouraged to personalise their bedrooms. Partial Provisional: All resident rooms in the new unit are suitable to meet the needs of residents requiring rest home or hospital level of care. There is adequate personal space provided in bedrooms, which allows residents and staff to move around within the room safely. Rooms are and can be personalised with furnishings, photos and other personal adornments. Twenty resident rooms are single, and one room is a large double.
Standard 1.4.5: Communal Areas For Entertainment,	FA	The communal areas include the main lounge downstairs and several smaller lounges and separate dining areas in each of the rest home and hospital units. The communal areas are easily and safely accessible for

Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		residents. Partial Provisional: The communal area comprises of a large lounge. The new wing will use the existing downstairs dining room. Management intend to refurbish and improve the current dining area.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. Chemical training has been provided and there are datasheets visible in the laundry/sluice area. All chemicals are in original containers with a closed system for laundry and cleaning needs. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility. All laundry is done in the on-site commercial laundry by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service. Partial Provisional: The existing laundry is situated downstairs in a utility area. There are separate clean and dirty entrances. The existing laundry is suitable to meet the needs of the additional 22 residents. The laundry has two commercial washing machines, one small washing machine and one large commercial dryer. The service has purchased new linen and linen trolleys, the sluice room is centrally positioned in the new wing (link 1.4.2.1).
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Low	There is an approved fire evacuation scheme dated 8 July 2005 in place. Fire evacuation drills are held at least six monthly. The last fire drill was completed December 2018. There is a business continuity plan and emergency management plan/manual in place. The civil defence kit is readily accessible in designated storage cupboards. The kit includes an up-to-date register of all residents' details. The facility is prepared for civil emergencies and has emergency lighting and BBQs. An emergency food supply, sufficient for three days, is kept in the kitchen. Water is contained in storage tanks, and each resident has a two-litre bottle of water in their wardrobe. Extra blankets are also available. Hoists have battery packs and there are batteries that can be used to operate electric beds in the event of a power failure. There is a list of names and contact details of staff so that they can easily be contacted in an emergency. The facility is secured during the hours of darkness. Staff are security conscious. Appropriate training, information, and equipment for responding to emergencies is provided. The call bell system is available in all areas and there are indicator panels in each area. During the tour of the facility, residents were observed to have easy access to the call bells. Residents were observed to have sensor mats in place. Residents interviewed stated that their bells are answered promptly.

		Partial provisional: There will be solar panels laid on the roof of the new Caradus wing, which will provide power for the whole building. There is sufficient water supply to serve all of the residents with the water bottles in each room and the emergency water in the tanks. The fire evacuation plan has been updated to include the new wings and is draft. The fire service has yet to sign off completion. Oxford Court has changed the fire water supply to one hydrant which will service the existing and new wing, to comply with regulations, and is working to ensure that all areas of the new and existing buildings are compliant with regulations.
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	General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open, allowing plenty of natural sunlight. Partial Provisional: The communal areas are light and airy, with external access to the courtyard deck. All resident rooms have external windows. Resident rooms have individual air conditioner units. The unit maintains 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	Oxford Court has an established infection control programme. The infection control programme, its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The enrolled nurse is the designated infection control nurse with support from the facility manager. The infection control programme is on the electronic system and reported on monthly. Monthly meetings are held by the infection control committee. Feedback from the meetings is given to staff via the monthly RN meetings and the minutes are available to staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff. There have been no outbreaks since the previous audit.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to	FA	An enrolled nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.

implement the infection control programme and meet the needs of the organisation.		
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	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred March 2018, next due in March 2019, and is included in the annual competencies (completed mid-year). The infection control coordinator has completed infection control training through the SDHB study days, and continues to keep updated by attending external education sessions and attending the SDHB Infection Control Forum Meetings. The IC nurse and IC team (comprising designated staff from each area) has good external support from the SDHB, and public health team who are readily available. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance	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 on the electronic system. 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 annually. Outcomes and

with agreed objectives, priorities, and methods that have been specified in the infection control programme.		actions are discussed at the combined health and safety/infection control meetings, RN/clinical and staff meetings and results posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical and facility manager.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The service is currently restraint-free, and there were no residents using enablers. The restraint register is reviewed on a monthly basis. The restraint coordinator (facility manager) confirmed the use of enablers/restraint is discussed at the monthly combined quality/health and safety/infection control meetings, and staff meetings. Restraint use is included in orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education is provided.

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 1.3.12.1 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 Low	Partial Provisional: There is a medication room in the new wings. The medication room is designed for purpose. The room is in the process of being fitted out and equipment has been ordered but not yet installed.	Partial Provisional: The medication room has not been completely fitted out and secured	Ensure the medication room includes locked cupboards where required, a medication trolley and is secure. Prior to occupancy

				days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	Partial Provisional: The new wings are still in the process of being completed and therefore a certificate for public use is yet to be obtained. Carpets and window furnishings, installation of handrails and painting are currently being completed. Outdoor areas are completed with planting planned for April. A planter box in the middle of the courtyard designed to accommodate a large tree which will provide shade. Hot water is installed but not yet turned on.	Partial Provisional: (i) The new wings are in the process of being completed and therefore a certificate for public use is yet to be completed. (ii) Hot water has not yet been turned on, so temperature requirements have not been tested. (iii) The sluice room has not yet been fitted out and secured.	(i) Provide evidence of a certificate of public use. (ii) Ensure hot water is turned on and the temperature monitored to ensure it is within the safe range. (iii) Ensure the sluice room has benches, shelves, a sluice sink, a sanitiser and is able to be secured. Prior to occupancy days
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Low	Partial provisional: The fire service has been onsite and have requested the water supply for fire is in one location to serve the whole building in line with legislation, this has been completed. Fire doors and ceilings have been replaced in the existing building, and wiring has been changed over to the new smoke alarm and sounding	Partial provisional: The fire evacuation plan has been	Ensure the amended fire evacuation plan has

		system. The fire evacuation plan has been updated to include the new wings and is in draft. The draft fire evacuation procedure is yet to be submitted to the fire service for approval.	updated to include the new wings and is draft.	been approved by the fire service. 60 days
Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.	PA Low	Partial provisional: There is a new call bell system being installed to the new building which will be continued throughout Oxford Court. The new electronic system, is wired throughout the new building, but has not yet been fully installed.	Partial provisional: The call bell system is not yet up and running.	Ensure the call bell system is installed and working. Prior to occupancy 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.