

Kapsan Enterprises Limited - Chadderton Rest Home

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 HealthShare 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:	Kapsan Enterprises Limited	
Premises audited:	Chadderton Rest Home	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 20 January 2021	End date: 20 January 2021
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:	15	

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

Kapsan Enterprises Limited, trading as Chadderton Rest Home, provides rest home level care for up to a maximum of 28 residents. Short stay /respite can also be provided subject to bed availability. There was one resident who was being funded as requiring hospital level care. There were 15 residents at the time of the audit. There have been no significant changes to the service since the previous audit.

Day to day operations and governance is provided by two directors, one of whom is the designated clinical nurse manager (CNM) and the other is the facility manager (FM) who oversees the building, grounds, equipment, quality and procurement.

This surveillance audit was conducted against a sub-set of the Health and Disability Services Standards and the service's contract with Auckland District Health Board (ADHB). The audit process included a review of areas of improvement identified during the last certification audit, review of relevant policies and procedures, samples of residents' and staff files, observations and interviews with residents, the directors, staff, and the general practitioner (GP). The GP and residents and spoke positively about the care provided. No family members were available for interview during the audit.

The previously identified area of improvement has been addressed. This audit resulted in three areas requiring improvement. These relate to essential notification reporting, evidence of a needs assessment for the resident requiring hospital level care and obtaining a current food control 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.

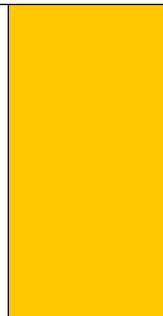


Standards applicable to this service fully attained.

Effective communication is maintained. Open disclosure is practiced when required. Staff provide residents and families with the information they need to make informed choices and give consent. Resident feedback is encouraged and followed up. Interpreter services are available should they be required. The complaints process meets the requirements of consumer rights legislation. 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.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Organisational performance is monitored. There is a documented and implemented quality and risk management system. The required policies and procedures are accessible. Quality activities are implemented. Quality data is collated and analysed. Improvements are made where required. Risks are identified and monitored. Adverse events are reported, documented, investigated and followed up.

Human resource processes are fully implemented in line with employment legislation. Staff have the required skills and qualifications. On-going education is provided. There is a sufficient number of staff on duty at all times.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Policies and procedures provide documented guidelines for access to service. Residents are assessed prior to entry to the service to confirm their level of care. The CNM is responsible for assessment, development and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs and routines. Interventions are appropriate and evaluated in a timely manner.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP) and these were current. Staff involved in medication administration are assessed as competent.

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are 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.
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There have been no changes to the facility since the last audit. There was a current building warrant of fitness and approved evacuation plan.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has commitment to the minimising and appropriate use of restraint/enablers. Restraint and enablers are only used as a last resort to maintain the resident's safety and comfort. There was one resident using bedrails as restraint at night for safety. Staff members received training regarding the management of challenging behaviours and restraint use.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control surveillance programme is fully implemented and appropriate to the size and scope of the service. All infections are recorded, with data collated each month, and then annually. Analysis and comparisons are made.

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	14	0	1	2	0	0
Criteria	0	35	0	1	2	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure meets consumer rights legislation. Information on the complaint process is provided to residents and families in the admission booklet. Complaints and compliment forms are readily available. Residents confirmed that staff and management were approachable and that they would not hesitate to make a complaint. There is evidence in staff meeting minutes that management encourage staff to support residents to complain if they are not satisfied. Verbal complaints are raised in resident meetings, with actions documented.</p> <p>The complaints register is maintained. There has been one complaint received since the last audit. This had been acknowledged in writing and was investigated immediately by the facility manager/director. The complaint was found to be unsubstantiated. There was evidence that the complaint was well managed and reported to the district health board (DHB) and the ministry of health (MOH).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Interviews and records sampled confirmed that residents and family/whanau are accorded the right to full and frank information or open disclosure. The environment is conducive to effective communication and interpreter services are provided if required. Policies and procedures are in place if the interpreter services are needed to be accessed. Staff education has been provided related to appropriate communication methods. Documentation regarding open disclosure following incidents/accidents was evident.</p>

<p>provide an environment conducive to effective communication.</p>		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The organisation is governed by the two directors. One of whom is the facility manager (FM) and the other the clinical nurse manager (CNM). The directors/managers have been in their positions for 15 years and have sufficient experience and qualifications to carry out these roles. For example, the CNM is a registered nurse who maintains a nursing portfolio, attends regular education to maintain skills and also works part time as an RN in a surgical hospital. The FM has qualification and experience in building management, health and safety and quality. The organisation is a current member of the NZ Aged Care Association.</p> <p>The quality/business/risk plan which is reviewed annually, outlines the purpose, values, scope, and direction of the organisation. This also contains detailed annual and longer-term goals. The plan was last reviewed in December 2020. A sample of directors/management meeting minutes confirmed regular discussions and actions to monitor organisational performance including corrective actions. For example, occupancy, human resources (HR), service performance, and any emerging risks and issues. Interview with FM and records sampled confirmed effective methods for ensuring services are provided in ways to meet the needs of residents.</p> <p>The service holds contracts with Auckland DHB, for rest home level care and respite. On the days of audit, 15 of the maximum 23 beds were occupied. There was one resident under 65 years old, who was admitted under ACC contract. There was also one resident who was requiring hospital level care (refer standard 1.3.3).</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a documented quality and risk management system with policies and procedures that guide best practice. Procedures cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. An additional COVID-19 manual has been purchased from the Health Quality and Safety Commission. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The FM is responsible for document control.</p> <p>Service delivery and organisational performance is monitored by internal audits and resident and family/whanau feedback. An internal audit schedule is developed annually, with flexibility to make changes in the schedule based on risk. Internal audits sampled confirmed corrective actions and closure when the improvement has been made. Results of audits and monthly analysis of complaints, incidents and accidents and infections are collated, with comparisons made, and discussed at staff meetings. Meeting minutes sampled confirmed ongoing review of all quality related data.</p> <p>Resident meetings occur every six weeks which family/whanau members are invited to attend. Minutes of these meetings confirmed ongoing consultation and inclusion of residents and their families in decision making. The 2020</p>

		<p>annual resident/family satisfaction survey indicated that residents were happy with the services provided, however there was general dissatisfaction with the reduced number of outings during the COVID-19 lockdown periods. Additional activities were provided during this time.</p> <p>There is a risk management programme. The biggest risk to the organisation is currently reduced occupancy and the FM has several strategies in place to minimise the impact of the risk. Risk management also includes a health and safety programme. Health and safety audits occur regularly and a hazard register is maintained. Review of staff meeting minutes confirmed that health and safety, hazards and management of any other risks is discussed at every meeting.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>Staff document adverse events on accident/incident forms. Adverse event forms sampled for 2020 were consistent in clearly describing and detailing the incident and recording who had been notified. Each falls event had attached records of post fall neurological observations. The managers review all incidents/accidents and investigate where necessary. Each incident form sampled included a management comment or preventative action for closure or follow-up. All events are categorised and collated, with comparisons made from the previous month and year. Adverse events are discussed at the staff meetings.</p> <p>There is one area requiring improvement regarding essential notification reporting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the</p>	<p>FA</p>	<p>Staffing policies and processes are based on good employment practice and relevant legislation. The recruitment process includes the required checks, vetting and validation of qualifications and practising certificates (APCs) where required. Copies of current practising certificates were sighted. Staff records sampled confirmed the organisation's policies are being consistently implemented and records are maintained. The director/FM routinely reviews personnel records to ensure compliance with policy and employment legislation.</p> <p>Staff orientation includes the essential components of service delivery. Staff records sampled included evidence of completed orientation and a performance review after a three-month period and then annually.</p> <p>Continuing education is planned on an annual basis and occurs each month. These include mandatory training requirements such as fire drills, first aid and medicines competency for those who administer medicines and other education to meet the requirements of the agreement with the DHB. There was evidence that additional one-off</p>

requirements of legislation.		training was provided where a gap in knowledge had been identified. Most health care assistants (HCAs) have educational achievements related to the care of the older person. The CNM is trained to complete interRAI assessments and maintains competency. Records sampled confirmed good staff attendance at training.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The roster confirmed more than adequate staff cover has been provided, with staff replaced in any unplanned absence. All staff have a current first aid certificate. The directors and care staff interviewed stated that staffing levels are adjusted to meet the changing needs of residents and occupancy.</p> <p>The FM is on site each weekday, and weekends if required. The CNM is onsite in excess of 20 hours per week. Both the CNM and FM are available after hours, with staff reporting that good access to advice is available when needed. There is a back-up registered nurse available in the event the CNM is absent. HCA's reported there was adequate staff available to complete the work allocated to them. This was supported by the residents and family members interviewed.</p> <p>There is a designated cleaner and cook, with HCA's completing some domestic duties as required.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medications were stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the CNM when the resident is transferred back to service from hospital, appointments, or when there are any medication changes. All medications were reviewed every three months and as required by the GP. Allergies were clearly indicated, and photos current for easy identification.</p> <p>An annual medication competency is completed for all staff administering medication. The HCA observed administering medicines followed the required medication guidelines and legislative requirements. There were no residents on controlled drugs at the time of the audit. Monitoring of medicine fridge temperatures was conducted regularly and deviations from normal were reported and attended to promptly. All expired medications were returned to the pharmacy in a timely manner.</p> <p>There was one resident who was self-administering inhalers and was assessed as competent. A self-medication policy is in place. Medication administration records were maintained.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid	PA Low	Meal services are prepared on site and served in the allocated dining room. An experienced and qualified cook is employed to oversee food services and is on site Monday to Friday for lunch and dinner. The other cook is rostered for the weekends. Diets were modified as required and the cooks confirmed awareness on dietary needs of the

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>residents. Meals were served warm in sizeable portions required by residents and any alternatives were offered as required. The residents' weights were monitored monthly and supplements were provided to residents with identified weight loss issues. The residents interviewed acknowledged satisfaction with the food service.</p> <p>The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates were on all containers. Records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning was conducted.</p> <p>An improvement relating to expired food control plan (FCP) is required.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>All care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders carried out. The registered nurse reported that the GP's medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person centred. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The planned activities were appropriate to the residents' needs and abilities. The activities were based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Social and recreational assessments were completed within two weeks of admission in consultation with the family/whanau. The activities were conducted by the DT with help from care staff during weekends. The DT in consultation with the CNM were involved in developing a monthly planner which was posted on the notice boards and given to all residents. The activities were varied and appropriate for rest home level of care residents and those under 65 years of age. These were offered from Monday to Sunday. Activities include housie, board games, indoor bowl, morning walk, music, in-house church services, bingo, one on one interactions, darts, movies, arts and craft. It was noted that there was a greater emphasis on providing activities during the COVID-19 lockdown period.</p> <p>Residents' files had a documented activity care plan that reflected their preferred activities of choice and were evaluated every six months or as necessary. The residents were observed to be participating in a variety of activities on the audit day. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents interviewed reported overall satisfaction with the level and variety of activities provided.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is documented on each shift by care staff in the progress notes. The CNM reads progress notes weekly and documents, as necessary. All noted changes by the HCA's were reported to the CNM in a timely manner.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occurred every six months or as residents' needs change. These were carried out by the CNM in conjunction with family, the GP and specialist service providers. Where progress was different from expected, the service responded by initiating changes to the service delivery plan.</p> <p>Short term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau were included and informed of all changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There have been no changes to the facility since the last audit. The current building warrant of fitness was sighted.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Trial evacuations are completed every six months as required. Records of staff attendance are maintained. There is an approved emergency evacuation plan.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with</p>	<p>FA</p>	<p>Surveillance of infections is carried out as specified in the infection control programme. The CNM reviews all reported infections, and these were documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. All infections are recorded on the infection register, this information is collated monthly, reviewed and analysed by the CNM who will advise staff and management of the outcome. The GP is notified if there is any resistance to antimicrobial agents and evidence of GP involvement and</p>

<p>agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>laboratory reporting was sighted. The surveillance programme is reviewed during the annual review of the infection control programme. This last occurred in October 2020.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Chadderton Rest House demonstrate that the use of restraint is actively minimised. There was one resident using a restraint and no one using enablers. The policies and procedures have definitions of restraints and enablers that are compliant to the standard. Staff receive ongoing training education in restraint minimisation and challenging behaviour. The CNM is the designated restraint coordinator.</p>

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)
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Moderate	The managers demonstrated an understanding regarding essential notification reporting with regard to complaints and adverse events. There had been one event that was reported to the MOH and the DHB. The required documentation and correspondence was sighted. However, the requirement to report to the MOH regarding the one hospital level care resident had not been made. Refer standard 1.3.3 for details regarding this resident.	Not all the required notification reporting had been made to the Ministry of Health.	<p>Complete notification reporting requirements.</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery,</p>	PA Low	The menu complies with recognised nutritional good menu planning practices appropriate for older people. The menu has been reviewed by the registered dietitian. There was a four-weekly rotating summer menu in place. The food control plan registration expired in June 2020. Completion of the plan was delayed due to the COVID-19 pandemic. Email correspondence was sighted	The food control plan registration expired in June 2020.	Provide evidence when the food control plan

and disposal comply with current legislation, and guidelines.		regarding the need to re-schedule.		registration is renewed. 90 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Moderate	<p>Initial admission assessments were completed in a timely manner and resident care plans were completed within three weeks of admission along with interRAI assessments. However, follow up assessments by the NASC team and notification to ministry of health were not completed for one resident. Closed out short term care plans were evidenced when there was a change in condition including (but not limited to): skin conditions, behaviour and mobility issues, chest infections, urinary tract infections and wound infections</p>	The required assessment determining level of care was not evident for one of the residents.	<p>Provide evidence of the assessment determining a change in the level of care.</p> <p>30 days</p>

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

No data to display

End of the report.