

Rosebank Residential Limited - Rosebank Home and Hospital

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:	Rosebank Residential Limited
Premises audited:	Rosebank Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 April 2021 End date: 28 April 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:	94

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

Rosebank Lifecare is a privately-owned aged care facility. Rosebank Lifecare provides care to up to 110 rest home and hospital level residents. On the day of audit, there were 94 residents.

This certification audit was conducted against the relevant Health and Disability Services 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, general practitioner (GP), relatives, staff and management.

Residents and families interviewed were complimentary of the care and support provided. The manager and clinical coordinator are well qualified for their roles.

This audit identified that improvements are required around; quality improvement data, resident profile information, progress notes and care planning.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Rosebank Lifecare provides care in a way that focuses on the individual resident. Cultural and spiritual assessments are undertaken on admission and during the review processes. Policies are implemented to support individual rights such as: privacy; dignity; abuse/neglect; culture; values and beliefs; complaints; advocacy; and informed consent. Information about the Code of Health and Disability Services Consumers' Rights (the Code) and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

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.
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Rosebank Lifecare has a quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident and staff meetings. Incidents documented demonstrated immediate follow-up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with

relevant information for safe work practice. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

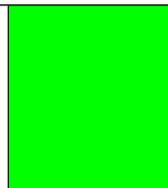
<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses manage entry to the service. An information pack is available prior to or on entry to the service. A registered nurse completes initial assessments including interRAI assessments, care plans and evaluations within the required timeframes. Care plans are integrated and include the involvement of allied health professionals. Residents and relatives interviewed confirmed they were involved in the care planning and review process. General practitioners review residents at least three monthly or more frequently if needed.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting and includes outings, entertainers and community interactions. Medicines are stored and managed appropriately in line with legislation and guidelines. Registered nurses and caregivers administering medications have completed annual competencies. The general practitioner has reviewed the medication charts at least three-monthly. Meals are prepared and cooked on site. The menus are reviewed by a dietitian. The menu is varied and provides meal options. Individual and special dietary needs are catered for. Residents interviewed were very 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.

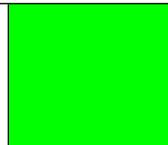


Standards applicable to this service fully attained.

The building has a current warrant of fitness. All rooms are single and are personalised. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activities. The dining and lounge seating placement encourages social interaction. Outdoor areas are well maintained, safe and accessible and provide seating and shade for residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are in their original containers and stored safely, and the laundry is well equipped. The facility is clean and tidy. Documented systems are in place for essential, emergency and security services. There is at least one staff member on duty with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The organisation actively minimises the use of restraint. At the time of the audit there were no residents using restraint and 17 using enablers. All staff receive training on restraint minimisation, enabler usage and prevention and/or de-escalation techniques.

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.

Infections are reported by staff and residents and monitored through the infection control surveillance programme by the infection control officer (registered nurse). There are infection prevention and control policies, procedures and a monitoring system in place. Training of staff and information to residents is delivered regularly. Infections are monitored and evaluated.

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	1	2	0	0
Criteria	0	89	0	1	3	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Families and residents are provided with information on admission which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with 15 care staff; nine caregivers, five registered nurses (RN) and one diversional therapist (DT) confirmed their understanding of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and relatives on admission. General consents including (but not limited to) the use of photographs, general treatment, premium room fees and outings were signed by the residents and part of the general admission agreement documents. Cardiopulmonary resuscitation status and advanced directives have been discussed with the general practitioner (GP), resident and relatives where appropriate. These were appropriately signed in the resident files reviewed. Copies of enduring power of attorney where known, were included in the resident file. There was evidence of an EPOA activation letter in one file. Caregivers interviewed confirmed verbal consent is obtained when delivering care. The resident files reviewed had a signed admission agreement.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services is included in the resident information pack that is provided to new residents and their family on admission. Advocacy brochures are also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy. Residents and relatives interviewed confirmed open visiting hours. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the manager using a complaint register. Five complaints were received in 2019, four made in 2020 and four received in 2021 year to date were reviewed, with evidence of appropriate follow-up actions taken. Documentation including follow-up letters and resolution demonstrated that complaints are being managed. A complaint made through the CDHB in March 2021 has been investigated and followed up. A letter from CDHB on 24 March 2021 informed the service they were closing the complaint.</p> <p>A complaint made through the Health and Disability Commissioner (HDC) in June 2019 is still open. The service investigated the complaint and included completed corrective actions taken in an email on 11 March 2020 to HDC. The service is waiting for a response from HDC. All documentation and correspondence are kept electronically. Staff interviewed were able to describe the process around reporting complaints. Discussions with the residents confirmed they were provided with information on complaints and complaints forms. Complaints forms are available at reception. Staff interviewed were able to describe the process around reporting complaints.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	FA	<p>There is an information pack given to prospective residents and families, which includes information about the Code and the Nationwide Advocacy Service. There is the opportunity to discuss aspects of the Code during the admission process. Eight residents; four rest home (including one on respite) and four hospital level and seven relatives; two rest home and five hospital level interviewed confirmed that</p>

rights.		information is provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The clinical coordinator or RN discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
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	A tour of the premises confirmed there are areas that support personal privacy for residents. Staff are respectful of residents' privacy and knock-on doors prior to entering resident rooms. Staff can describe definitions around abuse and neglect that align with policy. Residents and relatives interviewed confirmed that staff treat residents with respect. The service philosophy promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Caregivers described how choice is incorporated into resident care.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The Māori health plan policy for the service references local Māori health care providers and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. At the time of the audit there was one resident living at the facility who identified as Māori and was assessed for cultural needs with any plans documented in the care plan. The service has links with local district health board (DHB) for advice and support as required. Staff receive annual education on cultural awareness that begins during their induction to the service.
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 helping meet the cultural needs of its residents. The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. All residents and relatives interviewed reported that they are satisfied that their cultural and individual values are being met. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan which the resident (if appropriate) and/or their family/whānau are asked to consult on.
Standard 1.1.7: Discrimination Consumers are free from any	FA	Professional boundaries are reconfirmed through education/training sessions and staff meetings.

discrimination, coercion, harassment, sexual, financial, or other exploitation.		
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice 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 the recruitment process, the requirement to attend orientation and participate in ongoing in-service education/training. The 2020 resident/relative satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed demonstrated a sound understanding of principles of aged care and stated that they feel supported by the management team.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accidents and incidents are documented on a form that identifies if family/whānau have been informed (or not) of an accident/incident. Fifteen accident/incident forms reviewed identified family are kept informed. Relatives interviewed confirmed they were well informed. An interpreter policy and contact details of interpreters is available and used where indicated. Residents interviewed, confirmed they were given an explanation about the services and procedures and were orientated to the facility as part of the entry process. There are six monthly residents' meetings where any issues or concerns to residents can be discussed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Rosebank Lifecare is privately owned and governed by a Board. The service provides care for up to 110 residents in the care centre and 14 rest home beds in the studio apartment wing. At the time of the audit, there were 94 residents: 52 residents at rest home level (including two residents on respite) and 39 at hospital level (including one on an ACC contract and two on end-of-life contracts). All other residents were on the ARRC contract. The service has 56 dual purpose beds in total, 20 in the rest home West wing and 36 in the hospital East wing. There were two rest home residents and one hospital level resident in the serviced apartments. Notification for the one hospital level resident in the serviced apartments had been applied to the Ministry of Health at the time of the audit. An experienced manager (RN), who has been in the role for over 15 years, manages the service. The manager reports monthly to the Board on a variety of management issues. The current strategic plan and quality and risk management plans are being implemented. The manager receives support from a clinical coordinator who has been in the role for two and a half years. The manager is also supported by a quality/health and safety/infection control coordinator, staff educator, RNs and care staff.

		The manager and clinical coordinator have attended at least eight hours of training relating to managing an aged care facility, including attendance at regular local hospital meetings.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	In the absence of the facility manager, the clinical coordinator is in charge with support from the care staff.
<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>	PA Low	<p>Quality and risk management systems are implemented with quality initiatives that reflect evidence of evaluation and positive outcomes for residents and/or staff. Interviews with the manager, clinical coordinator and staff reflected their understanding of the quality and risk management systems that have been put into place. There is a 2020/2021 business plan and a risk and quality plan in place. The business plan has additional financial KPIs. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are reviewed by the manager and quality and health and safety coordinator every two years. New policies or changes to policy are communicated to staff.</p> <p>Monitoring of the quality and risk plan is through a series of meetings and reports. This includes a monthly report by the manager to the Board, including copies of the monthly RN and continuous quality improvement (CQI) meetings. Meetings include quarterly staff meetings; monthly RN; and bi-monthly CQI meetings. The quality and health and safety coordinator is responsible for collecting adverse event data. Quality data is collected around falls, skin tears, infections, and other adverse events. However, there is no identified analysis/trends or benchmarking of the quality data collected. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented when required and are signed off by the manager or quality/health and safety coordinator when completed.</p> <p>Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The resident/relative satisfaction survey for 2020 reported a 6% overall satisfaction increase from the 2019 resident/relative satisfaction survey. Management stated there were no corrective actions required for any areas of feedback. There is an</p>

		<p>implemented health and safety and risk management system in place. The service has a health and safety committee with specific role responsibilities. Hazard identification forms and a hazard register are in place. Health and safety is included in the orientation and annual staff training programme. Fall 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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes incident and accident information reported by staff on a paper-based system. A sample of 15 resident related incident reports for March and April 2021 were reviewed. All incident forms documented RN review and follow-up. This included neurological observations and 24-hour post-falls checks and ongoing assessments.</p> <p>Discussions with the manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three section 31 notifications reported since the last audit. Two unstageable pressure injuries in June 2019 and 2020, and one stage 3 pressure injury in January 2019. A gastro outbreak in September 2020 was notified to the Public Health authorities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of current practising certificates are retained. Nine staff files (one clinical coordinator, one RN, four caregivers, one quality/health and safety coordinator, one staff educator and one DT) were reviewed and evidenced that reference checks are completed before employment is offered. Staff are appraised annually on their performance. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>The in-service education programme for 2021 is being implemented. Discussions with the caregivers and RNs confirmed that online training is readily available. More than eight hours of staff development or in-service education has been provided annually. Caregivers are encouraged to complete qualifications. Competencies completed by staff included medication management, insulin administration, inhalers/nebulisers, wound care, manual handling, infection control, syringe driver and pain management. There are 43 caregivers in total. Completed Careerforce training as follows; nine have completed level four, twelve have completed level three and four have completed level two. There are currently fourteen RNs including the clinical coordinator, all of them are interRAI trained.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing levels guide, and human resource policies include staff rationale and skill mix. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. A staff availability list ensures that staff sickness and vacant shifts are covered. There is always at least one RN on duty. All RNs have a first aid qualification. The clinical coordinator works full-time, as does the manager. The manager and clinical coordinator rotate on-call cover three weeks and one week respectively. At the time of the audit, there were 94 residents in total across 2 wings (East and West) and in the serviced apartments.</p> <p>In the East wing (36 dual purpose beds) there were 27 hospital and six rest home residents, there is a RN on each shift. The RN is supported on morning shift by six caregivers (two short and four long). There are five caregivers rostered on afternoon shift (two long and three short shift) and there is one care worker on night shift.</p> <p>In the West wing (60 beds with 20 being dual purpose) there were 12 hospital and 46 rest home residents, there is a full-time RN on morning and afternoon shifts. The RN is supported on morning shift by six caregivers (two long and four short shifts). There are four caregivers on afternoon shift (three long and one short shift) and two care workers on night shift.</p> <p>In the serviced apartment wing (14 beds) there was one hospital and two rest home residents, there is a caregiver rostered on from 7.30 am to 12.30 pm and from 4.30 pm to 8.30 pm. Outside of these times, care is covered by staff in the adjacent East wing.</p> <p>One full-time DT, activity coordinator is supported by a second part-time activities coordinator and physiotherapist assistant. There are sufficient kitchen staff to meet service needs. There are designated staff employed to cover laundry and housekeeping. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>PA Moderate</p>	<p>All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so. Seven of the ten files reviewed had the necessary demographic, personal, clinical and health information available review. Clinical notes were current and integrated with the GP and allied health service provider notes. This includes interRAI assessment information. Registered nurses and caregiver entries in assessments and progress notes were legible, some entry errors were not corrected appropriately. Individual resident files demonstrated service integration. Archived records are held securely on site and are readily retrievable using a cataloguing system. No personal or private resident information was on public display during the audit.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has admission policies and processes in place. There is an information pack that outlines services able to be provided including palliative care and respite care. The admission pack included information on the code of rights, advocacy service and complaint process. Residents interviewed confirmed they had the opportunity to discuss the admission agreement with the manager. The admission agreement form in use aligns with the requirements of the ARRC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur as sighted in one resident file where a resident was transferred to hospital. Discussions with the RNs evidenced a good understanding of the transfer process.</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>	<p>FA</p>	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely. Registered nurses and caregivers' complete annual medication competencies and medication education. The RN is responsible for medication reconciliation against the robotic medication sachet system for regular and 'as required' medications. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. There were no standing orders. The medication fridge temperature and medication room temperature are being monitored daily and both were within acceptable limits. Twenty medication charts on the electronic medication system were reviewed.</p> <p>All charts had photo identification and allergy status documented. The effectiveness of 'as required' medications were recorded in the electronic medication system. All long-term medications charts had been reviewed by the GP three monthly. All eyedrops were dated on opening. Controlled medication is managed according to best practice and related legislation. There were three residents self-medicating with current self-medication competencies kept on file. The self-medicating competencies have been reviewed three-monthly by the GP. Medications were stored securely in the residents' rooms. All RNs completed a recent syringe driver competency. The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management.</p>
<p>Standard 1.3.13: Nutrition, Safe</p>	<p>FA</p>	<p>All meals at Rosebank Lifecare are prepared and cooked on site. There is a four-weekly seasonal menu which has been reviewed by a dietitian. Dietary needs are known with individual likes and</p>

<p>Food, And Fluid 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>dislikes accommodated. All food preferences are met. Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures and food temperatures prior to the food being served to the residents are recorded. A current food control plan is in place expiring June 2021. The kitchen also delivers food in hotboxes and covered trays to the residents' rooms and occupation right agreement (ORA) serviced apartments. The kitchen manager interviewed could describe the communication received from the clinical staff, this includes updated dietary profiles, dietitian instructions and residents identified with unintentional weight loss.</p> <p>Kitchen staff have completed food safety education. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and satisfaction surveys allow for the opportunity for resident feedback on the meals and food services generally. The latest resident satisfaction survey evidenced an overall improvement in satisfaction with the meal service compared to the previous year. Residents and relatives interviewed were satisfied with the meals and confirmed alternative food choices were offered when needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>Rosebank Lifecare has an accepting/declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available or the service cannot provide the assessed level of care. The referring agency, relatives and potential resident would be notified.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Resident files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate risk assessment tools (pressure injury, falls, continence, mobility and transfer, behaviour and nutrition) and were completed and reviewed within timeframes or when there was a change to a resident's health condition. InterRAI assessments have been completed for all residents and forms the basis of the long-term care plan (link 1.3.5.2).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service</p>	PA Moderate	<p>The interRAI assessment process informs the development of the resident's care plan. The long-term care plans are written and updated by RNs and integrated within the resident file which is readily available for caregivers. The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement in the care of the resident. Residents and relatives interviewed reported that they are involved in the care planning and review</p>

<p>delivery.</p>		<p>process. Short-term care plans are in use for acute changes in health status and either resolved or transferred to the long-term care plan as an ongoing problem. The resident on respite care had an initial care plan developed within the stated timeframe and addressed identified issues. There were two married couples residing in the facility with care plans referencing to management of their sexuality and intimacy.</p> <p>Five of nine long term resident' files reviewed evidenced care plans reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs of the residents were identified by the interRAI assessments. All files sighted consistently evidenced service integration with progress notes, activities note, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. Four of nine files reviewed required attention to care plan documentation as they did not fully describe all the required support the residents' needed to meet their assessed needs.</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>Except for those files referred to in 1.3.5.2, documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. Residents interviewed stated their needs are being met. If a resident's condition changes, the RN initiates a GP consultation, and completes a short-term care plan. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Residents identified as losing weight were referred to the resident's GP, who then decided whether a referral was needed. In all cases where a referral was made, dietitian input was in place. Interview with the clinical coordinator, verified the service is responsive to the requests by the dietitian, and residents referred had generally begun gaining weight with the addition of supplements.</p> <p>Care staff confirmed that care was provided as outlined in the documentation, handovers or verbal one-to-one direction. A wound log is maintained. There were twenty recorded wounds (including minor skin tears, two open wounds, lower leg ulcers). There were two residents with stage two pressure injuries on the day of the audit. In-house wound specialists and district nurses are available. Interventions sighted around residents with previous pressure injuries and wounds evidenced the services ability to manage and resolve these appropriately. There were three previous pressure injuries (one stage 3 and two unstageable) recorded and reported on a Section 31 notification form. Wound assessments and plans had been completed for all wounds.</p> <p>Evaluations and change of dressings had occurred at the documented frequency and progression was documented by the RN. Photos were taken to show progression towards healing. A range of equipment and resources was available, suited to the levels of care provided and in accordance with</p>

		<p>the residents' needs. There is specialist continence advice as required. Continence assessments have been completed at least six monthly, and adequate supplies were sighted. An education session has been held around continence and the caregivers interviewed were knowledgeable around the use and types of products available. Monitoring records sighted included weights, vital signs, physical checks, neurological observations, bowel records, food and fluids, blood sugar levels, and pain. Resident weights were noted to be monitored monthly or more frequently if necessary.</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>	FA	<p>The diversional therapist (DT) is employed for 40 hours a week and has been in the role for more than 10 years, she is supported by an activities assistant who works on Tuesdays to Saturdays. Both have first aid certificates and attend on site education sessions and local DT support meetings. There are regular volunteers who assist with delivery of activities across seven days a week. A resident profile is completed soon after admission. Each resident has an individual activity plan developed within three weeks, which is reviewed three-monthly. A monthly planner is developed by the activities team to include resident favourite activities such as housie, newspaper reading, floor games, crafts, quizzes, exercises, and outings. Church services and communion are held on Tuesdays. The activities are provided from 9 am to 4 pm. Visitors often visit after this time. Activities are also provided by caregivers and volunteers over the weekends. One resident interviewed expressed satisfaction that his cultural needs are met.</p> <p>There is interaction with the local school. Some residents attend a community groups including Ashburton RSA, Probus and a women's group. Recently the residents attended the aviation museum using a community van and wheelchair taxi. There are fortnightly outings available, the activities team try to accommodate residents' interests such as trips to the museum, coffee or community events. Special events are celebrated. One-on-one activities are provided for residents who choose not to participate in group activities, these include regular chats, reading of emails sent by relatives, hand massages and walks, or whatever the resident decides they would like. The service receives feedback on activities through one-on-one feedback, residents' meetings and annual satisfaction surveys. The latest resident satisfaction survey evidenced an overall improvement in satisfaction with activities compared to the previous year. Rosebank Lifecare uses social media to connect with the community and families.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The initial care plan is evaluated in consultation with the resident/relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review (MDT) with the manager, RN, caregiver and DT. There is a written evaluation against the resident goals that identifies progression towards meeting goals. Long-term care plans are updated with any changes to meet the</p>

		resident goals and needs. Short-term care plans were evident for the care and treatment of short-term problems for residents, and these had been evaluated, closed or transferred to the long-term care plan if the problem was ongoing (link 1.3.5.2).
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Rosebank Lifecare facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. There was evidence of referrals to the dietitian, district nurses, physiotherapy and the podiatrist.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	There are implemented policies in place to guide staff in waste management. Chemicals are stored safely in locked areas. Chemicals sighted were labelled correctly in the original containers, and safety data sheets and product information are readily available to staff. Gloves, aprons and visors are available, and staff were observed wearing personal protective clothing while carrying out their duties. Staff have completed chemical safety training.
<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>	FA	<p>The facility (including occupation right agreement apartments) has a current building warrant of fitness that expires 1 July 2021. There is a maintenance person available 40 hours a week and has overall responsibility for building compliance. The planned maintenance programme has been completed to date, including electrical testing and tagging of electrical equipment, calibration and testing of clinical equipment, and monthly hot water temperatures. Hot water temperatures in resident areas are maintained below 45 degrees. A recent deviation from the normal temperatures evidenced corrective actions been implemented. Essential contractors are available 24-hours.</p> <p>The physical environment allows easy access/movement for the residents and promotes independence for residents with mobility aids. There is a ramp to the front door of the facility and at exit doors. Outdoor areas have a maintained garden and patio areas. There is outdoor seating and shade provided. Occupation Right agreement apartments call bells are integrated with the rest of the facility. All apartments are easily accessible and within short distance from the nurse's station and</p>

		main dining room. The RN and caregivers interviewed stated they have all the equipment required to deliver safe resident cares.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	There are an adequate number of toilet and showering facilities, easily accessible and adequate for the size of the facility. Privacy locks are in place. Vacant/in use signage is on the toilet/shower rooms. All residents interviewed confirmed their privacy was maintained while attending to personal hygiene care. All rooms have a handbasin with flowing soap.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. There are no double rooms. Residents are encouraged to personalise their bedrooms. Care can be provided safely within the space of the occupation right agreement apartments. One resident has a hospital type electric bed to ensure comfort.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	A large dining room is adjacent to the kitchen area and provides adequate space for residents to enjoy their meals. There is a large lounge used for activities and a separate lounge area adjacent for residents who choose not to participate in activities to enjoy. Three smaller lounges and a chapel are available for private quiet time. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit. Residents interviewed reported they can move freely around the facility and staff assist them if required.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being</p>	FA	There are designated cleaners who complete the cleaning and laundry service. The cleaning trolley is well equipped, and all chemicals are labelled. Protective wear including plastic aprons, gloves, masks and goggles are available in the laundry. Staff observed on the day of audit were wearing correct protective clothing when carrying out their duties. Observation of the environment indicated a high standard of cleaning was maintained throughout. The laundry has a clean/dirty flow and operates over seven days a week. Internal audits monitor the effectiveness of the laundry service. Residents

provided.		expressed satisfaction with the cleaning and laundry services.
<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>	FA	<p>There are emergency management plans in place to ensure health, civil defence and other emergencies are included. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service, letter dated 18 November 2017. Six-monthly fire evacuation practice documentation was sighted, last completed on 21 February 2021. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency supplies (wheelie bins) are available in each of the East and West wings (checked every six months).</p> <p>Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including dry food, water (ceiling tanks; 1,200 litres), blankets and gas cooking (two BBQs and gas hobs in the kitchen). First aid kits are available in the two nurses' stations and the maintenance shed. Short term back-up power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is always on duty. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity. Night staff complete security checks.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. Panel heaters are in each room for residents to adjust the temperature to their liking. All resident rooms and communal areas have external windows that open allowing plenty of natural sunlight. Some rooms have a sliding door that opens to a courtyard.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>Rosebank Lifecare has an established infection control programme. The infection programme is appropriate for the size, complexity and degree of risk associated with the service. An RN is the designated infection control person with support from the clinical coordinator and all staff. Infection control matters are routinely discussed at the CQI, RN and staff meetings. Education has been provided for staff including use of PPE and handwashing. The effectiveness of the infection control programme has been reviewed, although there was a lack of identified trends within the data collation (link 1.2.3.6). There was a gastro related outbreak reported in September 2020 which affected several staff and residents. This was of short duration, appropriately managed and reported to public health authorities.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme. There is a RN responsible for infection prevention and control. The infection control team includes all staff through the CQI, RN and staff meeting. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. There is a comprehensive documented Covid-19 response plan available and is specific to the size and layout of the facility.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two-yearly.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The staff orientation programme includes infection control education. The infection control person has completed infection control updates and provides staff in-service education which last occurred in January 2021. Registered nurses completed a pandemic outbreak scenario workshop. Education is provided to residents during daily support. Residents interviewed were able to describe the information and education provided to them during the Covid-19 level restrictions and confirmed this is ongoing. Regular communication was provided to relatives via emails and the Rosebank Lifecare Facebook page. The clinical coordinator and infection control coordinator completed formal infection control education to satisfy the requirements related to the Health and Disability Sector Standards.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>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</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored. Outcomes and actions are discussed at CQI, RN and staff meetings and results published for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Surveillance data are in a tabled format and trends are difficult to identify (link 1.2.3.6).</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents using restraints and 17 residents using enablers. Enablers include 12 bed loops, one bedrail and four lap belts. The restraint coordinator is the clinical coordinator who reviews all residents with restraint and enablers monthly. The coordinator also monitors and maintains records, checks staff compliance and documentation. Representatives on the restraint committee are the DT manager, clinical coordinator, RNs and caregivers. Staff interviews, and records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</p> <p>Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.2. Staff education including assessing staff competency on RMSP/enablers has been provided. Restraint/enabler use is discussed as part of staff meetings and in the CQI and RN meetings. Three files of residents using an enabler reflected evidence of an assessment, consent process and reviews. Two of three files care plans included the type of enabler, and risks associated with its use (link 1.3.5.2). Monitoring had been completed.</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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	The quality and health and safety coordinator is responsible for collecting adverse event data. Quality data is collected around falls, skin tears, infections, and other adverse events, however the data is not being trended or analysed or benchmarked to identified opportunities for improvement. Quality data is fed back to staff at meetings.	Quality data is collected, however there is no documented evidence of analysis/trends or benchmarking of the quality data to identify opportunities for improvement	Ensure analysis/trends of quality data collected is documented to identify opportunities for improvement. 90 days
Criterion 1.2.9.1 Information is	PA Moderate	The service retains relevant and appropriate information to identify residents and track	Three resident files (respite, EOL and ACC) reviewed did not contain a fully completed resident profile document. Medical conditions including past and	Ensure all individual information including relevant medical conditions

<p>entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.</p>		<p>records. Residents required an interRAI assessment as a contractual requirement had a personal profile, demographic information, past and present health information/medical conditions readily available in printed format. Three residents who do not require an interRAI assessment as a contractual requirement had incomplete profile documents.</p>	<p>present health information was not completed.</p>	<p>and health information is maintained and available.</p> <p>60 days</p>
<p>Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.</p>	<p>PA Moderate</p>	<p>Registered nurses' designations are clearly identifiable and entries in progress notes are dated and signed. Eight of ten resident files evidenced several entries in progress notes made by caregivers without a designation. The clinical coordinator confirmed this has been previously addressed in staff meetings. Inaccurate information is not always crossed out, dated and signed.</p>	<p>The following shortfalls have been identified: i) Designations of caregivers are not always clearly documented to identify the relevant level of input into the care of the resident. ii) Progress notes in two files and one daily task allocation document evidenced use of white out to erase mistakes.</p>	<p>Ensure staff sign progress notes using a clear designation and correct documentation errors in a way that preserves the original entry.</p> <p>60 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to</p>	<p>PA Moderate</p>	<p>Nine long-term care plans were reviewed. Five files' assessments, medical diagnosis, progress notes, short term care plans, observations, interviews and monitoring charts indicated that issues/symptoms/conditions</p>	<p>Care plans do not consistently describe the support/interventions required to guide care delivery and meet individual outcomes. The following files identified shortfalls within the long-term care plan: (i) One rest home resident with challenging behaviour and frequent falls (tracer) were assessed frequently, but interventions were insufficient to guide staff in the management of this; (ii) One rest home resident was assessed and</p>	<p>Ensure management of assessed issues/symptoms/conditions are consistent with the resident desired outcomes.</p> <p>60 days</p>

<p>achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>were identified during the nursing process and monitored in the long-term care plan. Four of nine files evidenced interventions were not documented to a level of detail to sufficiently guide care staff in the delivery of care.</p>	<p>monitored for using an enabler, however the type of enabler and frequency of monitoring were not evidenced in the care plan (this was updated on day of audit); (iii) Respiratory symptoms were triggered in the interRAI client summary form, but not addressed in the care plan, this also includes the medication needs; the same resident had several short-term care plans for the same ongoing symptoms that were not transferred to the long-term care plan (tracer); and</p> <p>iv) One hospital level resident on palliative care with inconsistent pain had several pain assessments forms completed, however his pain, comfort and palliative symptom management were not addressed to a level of detail to guide staff in the management of cares.</p>	
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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.