

# C D Hodson - Westella Homestead

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## 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 Q-Audit 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:

<b>Legal entity:</b>	C D Hodson
<b>Premises audited:</b>	Westella Homestead
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 24 May 2021    End date: 25 May 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	23

# Executive summary of the audit

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## 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

Westella Homestead provides rest home and dementia level of care for up to 26 residents. There were 23 residents residing at the facility on the audit days.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the district health board. The audit process included the review of policies and procedures, review of residents and staff files, and observations and interviews with rest home level care residents, family members, management, staff and a general practitioner.

The residents and family members spoke positively about the care provided.

There were two areas identified as requiring improvement relating to: good practice and infection prevention and control.

## Consumer rights

<p>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.</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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Information regarding the Health and Disability Commissioner's code of Health and Disability Services Consumers Rights, the complaints process, and the Nationwide Health and Disability Advocacy service is accessible. This information is brought to the attention of residents and their families on admission to the facility. Residents and family members confirmed their rights are being met; staff are respectful of their needs and communication is appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent is practised, and written consent is gained when required. Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

There are policies and procedures about the management of complaints that align with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services consumers rights. A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

CD Hodson is the governing body and are responsible for the services provided at Westella Homestead. Dalcam Healthcare Management Limited is contracted to provide management services. The business, strategic and quality and risk management plans include the risks, scope, direction, goals, values, and mission statement of the organisation and Westella Homestead. There are systems in place for monitoring the services provided, including regular monthly reporting by management to the directors.

The facility is managed by an experienced and qualified general manager employed by Dalcam Healthcare Management Limited. A clinical Manager and a Clinical Team Leader, both registered nurses with aged care experience are responsible for the oversight of the clinical services in the facility.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented with corrective actions implemented. Facility meetings are held where there is reporting on various clinical indicators, quality and risk issues, and discussions of identified trends. Policies and procedures support service delivery and are current and reviewed regularly.

There are policies and procedures on human resource management. A mandatory education programme is provided for staff. Staffing levels and skill mix meet the changing needs of residents that is based on best practice.

Resident information is accurately recorded, securely stored and not accessible to unauthorised persons.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after the resident's admission to the facility.

The interRAI assessment is used to identify residents' needs and these are completed within the required timeframes. The general practitioner completes a medical assessment on the resident's admission and reviews occur thereafter on a regular basis.

Long term care plans are developed and implemented within the required timeframes, they are individualised and based on an integrated range of clinical information. Residents' needs, goals and outcomes are identified. All residents' files reviewed demonstrated evaluations were completed six-monthly or when the resident's condition changes. Residents and their relatives are involved in the care planning process.

Short term care plans are in place to manage short term issues or problems as they arise. Handovers between shifts guide continuity of care and teamwork is encouraged.

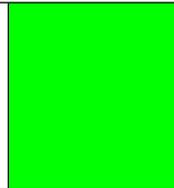
An electronic medication management system is in place. Medication management is in line with the legislation and contractual requirements. Medications are administered by the registered nurse and care givers who have completed current medication competency requirements.

The activity programme is managed by a diversional therapist. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The service uses its facility van for outings in the community.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control plan. Kitchen staff have food safety qualifications.

## 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 building systems services report displayed. There is a reactive and preventative maintenance programme, and this includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

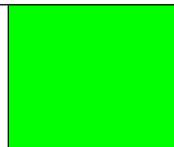
Residents' bedrooms are of an appropriate size to allow for care to be provided. Lounges, dining areas, and sitting areas are available for residents and their visitors. External areas and gardens are safe and secure for residents to mobilise around.

A call bell system is available to allow residents to access help when needed. Security systems are in place with regular fire drills completed.

Protective equipment and clothing is provided and used by staff. Chemicals are safely stored. The laundry service is conducted off site apart from some residents' personal clothes which are cleaned on site. Cleaning of the facility is conducted by household staff and monitored.

## 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.

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse. On the day of the on-site audit there were no restraints or enablers in use. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Infection prevention and control policies and procedures which comply with current legislation are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current best practice and are readily available for staff.

Infection control education is provided by the clinical services manager and the clinical team leader. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to relevant staff. General practitioner (GP), or other specialised input, is sought as required. Staff and residents reported that they are informed of any infection issues within the facility.

## 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)
<b>Standards</b>	0	43	0	1	1	0	0
<b>Criteria</b>	0	91	0	1	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Policies, procedures, and processes are in place to meet the obligations in relation to the Code of Health and Disability Services Consumers Rights (the Code). Staff interviewed understood the requirements of the Code. Staff were respectful of residents' rights as observed in their communications with residents and family members; encouraging residents independence and maintain residents' dignity and privacy. Training in the code is included in the staff orientation process and part of the ongoing training.</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>The DHL informed consent policy guides staff in relation to informed consent and staff interviewed understood the principles and practice of informed consent.</p> <p>The residents' clinical notes evidenced documented consents using the organisations standard consent form that includes consent for photographs, outings, and collection and sharing of health information. Consent is also obtained on as-required basis, such as for influenza or covid 19 vaccinations.</p> <p>There was evidence of advanced directives signed by the general practitioner. Residents interviewed confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed</p>

		<p>about what was happening with their relative and consulted when treatment changes were being considered.</p> <p>Staff were observed gaining verbal consent for day-to-day care.</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 the advocacy service is included in the staff orientation programme and in the ongoing education for staff. Staff demonstrated understanding of the advocacy service, with contact details for the service readily available.</p> <p>Residents' family members are provided with information on the advocacy service as part of the admission process. Family members interviewed confirmed their awareness of the service and how to access this.</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>Residents are encouraged to maintain their interests and visits with their families. The park-like secure grounds allow the residents to move freely from inside to the outside of the facility. The activities programme includes regular outings in the facility's van. Community groups and entertainers also visit the facility.</p> <p>The facility welcomes visitors and has unrestricted visiting hours. Family members advised they feel welcome when they visit.</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>Policies and procedures relating to complaints management are compliant with Right 10 of the Code. Systems are in place that ensure residents and their family are advised on entry to the facility of the complaints processes and the Code. The complaints forms are displayed and accessible in the reception area. Staff interviews confirmed their awareness of the complaints processes. Families interviewed demonstrated an understanding and awareness of these processes.</p> <p>The general manager is responsible for complaints management. A complaint register is maintained that indicated one complaint was received by the facility at audit, processes were followed, and the complaint was resolved the following day.</p> <p>There are no current complaints being investigated by external agencies.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>During the admission process, their family are given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service. Posters on the Code are displayed in English and Te Reo Māori in the facility.</p> <p>Residents and family members interviewed were familiar with the code and the advocacy service. Family stated they would feel comfortable raising issues with staff and management.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Staff communicate their knowledge about the need to maintain resident's privacy and were observed doing so throughout the audit.</p> <p>Residents are encouraged to maintain their independence by participating in activities and outings, confirmed at residents and family interviews. Residents' care plans include documentation relating to residents' abilities and strategies to maximise independence. Residents' clinical records sampled confirmed that resident's individual cultural, religious, social needs, values and beliefs were identified, documented, and incorporated into their care plan.</p> <p>The policy on abuse and neglect was understood by staff interviewed, including what to do should there be any signs. Education on abuse and neglect is part of the staff orientation programme.</p> <p>The residents and their families confirmed they receive services in a manner that has regard for their dignity, privacy, spirituality, and choices.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>The service has a Māori Health Plan and Māori Plan, Treaty of Waitangi that guides staff in meeting the needs of residents who identify as Maori. Any additional cultural support, if required, would be accessed by the utilisation of staff members who identify as Māori or accessed locally, confirmed at general manager (GM) meeting. At the time of audit there were three residents who identified as Maori. The review of their clinical notes and staff interviews confirmed their cultural needs were being met. Two staff members identify as Māori.</p> <p>Family/whanau are able to visit their family members at the facility and are part of the care planning and evaluation care process. Interviews with family confirmed they were informed of their family member's changes in condition when this occurred, are invited to residents' meetings, receive email notifications and are involved when required in reviews.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The individual preferences, values and beliefs of residents are documented in the care plans reviewed. Residents and family members stated they had been consulted about resident's individual ethnic, cultural, spiritual values, and beliefs, and confirmed that these were respected.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members stated that residents were free from any type or discrimination or exploitation.</p> <p>Staff are guided by policies and procedures and communicated understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. Staff orientation includes information related to all forms of discrimination and exploitation, professional boundaries and expected behaviours.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	PA Moderate	<p>Westella Homestead implements the Dalcam Healthcare Limited (DHL) policies and procedures which are based on current legislation.</p> <p>There is a DHL policy for falls risk management and a falls risk observation form. Incident/accident reports reviewed at audit evidenced that where a resident had sustained an injury or a fall the RN had undertaken a physical assessment of the resident, such as a skin assessment, a falls assessment, blood pressure and neurological assessment where appropriate. However, the falls management policy regarding neurological observations did not reflect best practice.</p> <p>The service encourages and promotes practice and input from external specialist services and allied health professionals for example physiotherapists if required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>A review of the electronic accident/incident forms shows timely communication with residents (when applicable) and or family members. Communication with family members is also recorded on the residents' clinical files. The residents and family members stated they were kept informed about any changes to their own or their relative's status, and they were advised about incidents or accidents and the outcome of medical reviews. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p>

		<p>Residents and family members are informed of residents' meetings and the meeting minutes reviewed evidenced information is shared. Family members are kept informed by the general managers regular emails. This was implemented during Covid-19 lock down and has been maintained as feedback for the new system was positive.</p> <p>Interpreter services can be accessed via the district health board (DHB) or Interpreting New Zealand when required.</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>Westella Homestead is owned by CD Hodson as a sole trader. Dalcam Healthcare Management Limited (DHML) is contracted to provide management for Westella Homestead. Dalcam Healthcare Management Limited is part of the Dalcam Healthcare Group Limited (DHGL). One of the directors of the DHGL is the sole owner of Westella Homestead.</p> <p>The DHML team includes a general manager (GM) and a Clinical Manager (CM). Monthly progress reports with identified indicators are presented to the directors.</p> <p>There is a clear mission of the organisation with values and goals and these are communicated in the organisation's and the Westella Homestead's strategic and business plans.</p> <p>The GM is responsible for the overall management of the service and has been in this role over 8 years. The GM has experience in health and manages three of the DHGL facilities based in the North Island. The GM confirmed knowledge of the sector through membership of relevant associations.</p> <p>The GM is supported by the CM and a Westella Homestead Clinical Team Leader (CTL). The CM and CTL are registered nurses (RN) with experience in dementia services and aged care. The Clinical Team Leader (CTL) has been employed since August 2019.</p> <p>The facility can provide care for up to 26 residents, with 23 beds occupied at the audit. This included two residents requiring rest home level care, 20 residents requiring dementia care and one respite dementia level care. There were no residents under the age of 65 years.</p> <p>The facility has contracts with the DHB for the provision of rest home, dementia care, and to provide day care services and respite dementia level care.</p>

<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>	<p>FA</p>	<p>In the absence of the GM, the CM is delegated to perform this role, The Westella homestead clinical team lead is supported from the DHML management team. If on leave the CM has oversight of clinical care and a RN will be assigned the day-to-day responsibility, confirmed at management interviews.</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>Westella Homestead uses the Dalcam Healthcare Limited quality and risk management framework that is documented to guide practice.</p> <p>The service implements organisational policies and procedures to support service delivery, including policies on interRAI. All policies are subjected to reviews as required with all policies current. The DHGL reviews all policies with input from relevant staff and management. Policies are linked to the Health and Disability Sector Standards current and applicable legislation and evidenced best practice guidelines. (Refer to 1.1.8.1).</p> <p>Policies are readily available to staff. New and revised policies are presented to staff to read and discuss at staff meetings to evidence that they have understood the policy.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, key performance indicators, and implementation of an internal audit programme. The review of the quality management data evidenced the internal audit schedule was adhered to. The patient satisfaction survey was not completed in 2020 as a direct result of covid-19. The 2021 survey was due to be sent out in May 2021. The 2019 data was collated and analysed, and corrective actions where required implemented and evaluated.</p> <p>Facility meetings are conducted monthly, and minutes evidenced communication with staff around aspects of quality improvement and risk management.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme.</p> <p>There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed, and risks are minimised or isolated.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and</p>	<p>FA</p>	<p>Staff understood the adverse event reporting process and were able to describe the importance of recording near misses. Staff are documenting adverse, unplanned or untoward events in the electronic management system. An incident/accident is documented in the electronic management system by staff who either witnessed an</p>

<p>reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>adverse event or were the first to respond. The electronic management system is reviewed by management and signed off when completed. The registered nurses undertake assessments of residents following an incident. Neurological observations and falls risk assessments are completed following incidents/accidents as per the DHGL policy. (Refer to 1.1.8.1).</p> <p>Policy and procedures comply with essential reporting, for example, health and safety, human resources, and infection control. The GM is aware of situations which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, sentinel events, notifications of pressure injury, and infectious disease outbreaks. Authorities have been notified of a recent missing resident, who was later found in a wasp's nest and required transfer to a higher level of care for treatment.</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>	<p>FA</p>	<p>Written policies and procedures in relation to human resource management are available. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice. The selection of new staff is the responsibility of the GM and CM. The skills and knowledge for each position are documented in job descriptions which outline accountability, responsibilities, and authority. These were reviewed in staff files along with employment agreements, reference checks and police vetting.</p> <p>Interviews with care givers confirmed new caregivers are paired with a senior caregiver for shifts or until they demonstrate competency on a number of tasks including personal cares for residents. Caregivers confirmed their roles in supporting and buddying new staff. Completed orientations were not sighted in some staff files reviewed. An audit completed in May identified this issue. An action plan was opened to address actions including the development of a new front sheet in all personal files that identifies the orientation programme required. A corrective action plan was not opened as the facility had acknowledged the issue and had opened and implemented an action plan.</p> <p>Competency assessment questionnaires for relevant competencies required for specific positions such as hoist, handwashing, medication management and assisting residents that require showering were sighted in staff education files reviewed.</p> <p>There was one trained interRAI competent RN, the CTL. The second RN is enrolled for training.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>Staffing levels meet contractual requirements. The GM, CM and the CTL are available</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>during weekdays and on call after hours and weekends. A registered nurse is rostered on each morning shift and supported by sufficient numbers of caregivers.</p> <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of the residents. An afterhours on call roster is in place, with staff reporting that advice is available from another Dalcam Healthcare limited property located across the road from Westella Homestead.</p> <p>Residents and families reported staff provide them with adequate care. Caregivers reported there are adequate staff available and that they are able to get through their work.</p> <p>Observations and a review of four weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence.</p> <p>At least one staff member on duty has a current first aid certificate.</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>FA</p>	<p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of residents' records. Files, relevant resident care, and support information could be accessed in a timely manner. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>Residents' files are maintained securely. Electronic data is password protected and can only be accessed by designated staff. Archived material is also kept securely and easily retrievable.</p> <p>All components of the residents' records reviewed include the resident's unique identifier. The clinical records reviewed are integrated, including information such as medical notes, assessment information, and the reports from other health professionals. Entries are legible, dated and signed by the caregiver, RN or other health professional and include their designation. Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals.</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</p>	<p>FA</p>	<p>Needs Assessment and Service Coordination (NASC) assessments are completed for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. There is a comprehensive information pack provided to all residents and</p>

<p>identified.</p>		<p>their families prior to admission. Review of residents' files confirmed entry to service processes are implemented, ensuring compliance with entry criteria.</p> <p>Residents and family members interviewed stated they were satisfied with the admission process and that it had been completed in a timely manner. Information about Westella Homestead had been made available to them. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</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>Transition, exit, discharge or transfer is managed in a planned and coordinated manner.</p> <p>Interviews with RNs and review of residents' files confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers. A transfer form accompanies residents when a patient is moved to another service or facility. Follow-up occurs to check that the resident is settled.</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>A current medication management policy identifies all aspects of medicine management in line with the relevant legislation and guidelines.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices are in line with legislation, protocols and guidelines. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities were documented on the electronic medication chart.</p> <p>The service uses pharmacy pre-packaged medicines that are checked by an RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing orders used at the facility.</p> <p>Review of the medication fridge evidenced that the service does not store or hold vaccines and interview with the RN confirmed this. The medication refrigerator temperatures and medication room temperatures are monitored daily.</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks and six monthly stocktakes of medications are conducted in line with policy and legislation.</p> <p>The staff observed administering medication demonstrated knowledge and at interview</p>

		<p>demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. The RN oversees the use of all pro re nata (PRN) medicines and documentation made regarding effectiveness on the electronic medication record and in the progress notes was sighted. Current medication competencies were evident in staff files.</p> <p>There were no residents self-administering medication at the time of the audit.</p>
<p>Standard 1.3.13: Nutrition, Safe 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>FA</p>	<p>All meals are prepared on site and served in the dining rooms or in the resident rooms if requested. The seasonal menu has been reviewed by a dietitian, with the winter menu implemented at the time of audit. The food control plan expires in May 2022. Food management training and certificates for cooks were sighted.</p> <p>Food temperatures are monitored appropriately and recorded. The kitchen staff have relevant food hygiene and infection control training. The kitchen was observed to be clean, and the cleaning schedules sighted.</p> <p>A nutritional assessment is undertaken for each resident on admission by the RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident's dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning.</p> <p>Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. Residents and families interviewed stated that they were satisfied with the meals provided.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated.</p>
<p>Standard 1.3.2: Declining Referral/Entry To</p>	<p>FA</p>	<p>The service has a process in place if access is declined. When residents are declined access to the service, residents and their family/whānau, the referring agency and general</p>

<p>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>		<p>practitioner (GP) are informed of the decline to entry. The resident would be declined entry if care requirements are not within the scope of the service or if a bed is not available. A waiting list is maintained.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial nursing assessments which include dietary needs, behaviour, pressure injury, falls risk and continence needs and the initial care plan are completed within 24 hours of admission. The initial care plan guides care for the first three weeks. RNs complete the interRAI assessment within the required timeframes. The long-term care plan is based on the interRAI assessment outcomes. Assessments are recorded, reflecting data from a range of sources, including: the resident; family/whānau; the GP/NP and specialists.</p> <p>Policies and protocols are in place to ensure continuity of service delivery. Assessment tools are reviewed at least six-monthly, including falls, behaviour, dietary, pressure injury and continence. Interviews with residents and families confirmed their involvement in the assessments, care planning, review, treatment, and evaluation of care.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Long term care plans are developed with resident and family/whānau involvement. All residents' files sampled had an individualised long-term care plan. Long term care plans describe interventions in sufficient details to meet residents' assessed needs. Short-term care plans are developed for the management of acute problems.</p> <p>Review of resident files showed service integration with clinical records, activities notes, and medical and allied health professionals' reports and letters. Interviews with residents confirmed that they have input into their care planning and review, and that the care provided meets their 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>Long term care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. Care planning includes specific interventions for long-term and acute problems. Interventions are reviewed within required timeframes and updated if there are changes in the health status of a resident.</p> <p>The GP documentation and records reviewed were current. The GP interviewed confirmed that they were notified of problems in a timely manner, medical orders were followed, and that care was of a good standard. After hours medical care is provided</p>

		<p>through a local GP practice.</p> <p>There was evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were recorded and measurements taken where this was required. Where wounds required additional specialist input, this was initiated.</p> <p>Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Family communication is recorded in the residents' files. The nursing progress notes are recorded and maintained.</p> <p>Monthly observations such as weight and blood pressure were completed and are up to date.</p> <p>Residents and the family members interviewed expressed satisfaction with the care provided.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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 residents' activities programme is implemented by the diversional therapist and an activity officer who is undertaking diversional therapy training. Activities for the residents are provided seven days a week, from 9.30am to 6 pm. The activities programme is displayed on the residents' noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural and community events. Regular van outings into the community are arranged.</p> <p>The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the RN. Information on residents' interests, family and previous occupations is gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed every six months at the same time the care plans are reviewed and are part of the formal six-monthly multidisciplinary review process.</p> <p>All residents assessed as needing secure dementia care have a behaviour assessment on admission. There are interventions in the LTCPs to address challenging behaviour including the use of individual one-on-one time and activities. There are specific 24- hour activity plans in place to guide staff in addressing residents' challenging behaviour throughout a 24-hour period.</p> <p>The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Long term care plans are evaluated every six months in conjunction with the interRAI re-assessments or as the residents needs change. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. Residents and family interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident's records and documented in the individual resident files reviewed.</p>
<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	<p>The service facilitates access to other medical and non-medical services. Where needed, referrals are sent to ensure other health services, including specialist care is provided for the resident. Referral forms and documentation are maintained on resident files. Referrals are regularly followed up. Communication records reviewed in the residents' files, confirmed family/whānau are kept informed of the referral process.</p>
<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	<p>There are policies and procedures in place for the management of waste and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill event occur.</p> <p>Protective clothing and equipment appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff.</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>	FA	<p>A current building systems services and specified system status reports are displayed.</p> <p>There is a preventative and reactive maintenance programme in place. Staff are aware of the process of reactive maintenance requests to ensure timely repairs are conducted, confirmed at staff and maintenance interviews. The maintenance staff member is new and supported by the GM.</p> <p>Visual observations evidenced the facility and equipment are maintained to an adequate</p>

		<p>standard, documentation reviewed, and staff interviews confirmed this. The testing and tagging of equipment and calibration of biomedical equipment is current.</p> <p>The external areas are safely maintained and are appropriate to the resident group and setting. Residents are protected from risks associated with being outside.</p> <p>Staff interviews confirmed they have appropriate equipment to meet the resident's needs. Residents were observed to move freely around the facility and the accommodation meets their needs.</p> <p>The facility has a van that is used for residents' outings, and this has a current registration and warrant of fitness.</p>
<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>	<p>FA</p>	<p>There are adequate number of communal toilets and bathrooms of an appropriate design for residents. Two communal bathrooms were being refurbished at audit. The strategic plan indicates all communal toilets and bathrooms are to be refurbished.</p> <p>The facility consists of two levels. The lower level consists of 10 rooms with eight having en suite facilities and two toilets and one bathroom. The upper level has 16 bedrooms with three bathrooms and five toilets.</p> <p>Separate toilets are available for staff and visitors. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Communal toilets and showers have a system that indicates if they are vacant or occupied. Appropriate secured handrails are provided along with other equipment/accessories that are required to promote resident independence.</p> <p>Hot water temperatures are monitored monthly. When there have been hot water temperatures above the recommended safe temperature, action is taken, and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.</p>
<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>	<p>FA</p>	<p>Residents' bedrooms are personalised to varying degrees. The bedrooms are single occupancy rooms. Bedrooms are large enough to allow staff and equipment to move around safely and provide personal space for residents.</p> <p>The facility is a two-level facility with residents' bedrooms on both levels. Access is via a lift or a staircase. A criterion defines which residents are suitable for residing in the upper-level bedrooms. A caregiver is stationed at night to monitor the stairway.</p>

<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	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<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 provided.</p>	FA	<p>Cleaning and laundry policies and procedures are available. Linen is undertaken off site by a contracted provider. Residents personal clothing, such as woollen clothes are washed on site, or by family members. There is a dirty to clean flow and handling of soiled linen provided in the laundry. The GM described the management of laundry including the transportation, sorting, storage, laundering and the return of clean laundry to residents.</p> <p>There is a small, designated cleaning team who have received appropriate training. There are safe and secure storage areas for cleaning equipment and chemicals and staff have access to these as required. A sluice is available in the dirty laundry area for the disposal of soiled water/waste. Handwashing facilities are available throughout the facility along with alcohol gels in safe locations.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme.</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>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. The fire evacuation scheme has been approved by the New Zealand fire Services. The trial fire evacuations are conducted six monthly with a copy sent to the New Zealand Fire Service. The last fire evacuation was conducted in May 2021. The GM has completed fire warden training. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>There is emergency lighting, gas for cooking, emergency water supply, blankets available in case of an emergency. Water storage tanks are located around the complex and are regularly tested for suitability.</p> <p>Call bells alert staff to residents requiring assistance.</p> <p>There is one driveway to the facility and two secure gates that electronically open when coming into the facility. Cameras, secure' wristbands and Global Positioning System (GPS) are in place for vulnerable residents. One secure gate at the rear of the property is</p>

		<p>utilised by contractors.</p> <p>The gates, doors and windows are locked at a predetermined time at night.</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>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden or small patio areas. Heating is provided by wall heaters in residents' rooms and night stores in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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>	PA Low	<p>Westella Homestead provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. The infection control programme is appropriate for the size and complexity of the service. However, the infection control programme is not site specific and is not reviewed annually.</p> <p>A RN is the infection control nurse (ICN) and has access to external specialist advice from the DHB infection control nurse. A documented role description for the ICN, including role and responsibilities, is in place. As the ICN is newly employed they are supported by the clinical services manager (CSM) and CTL.</p> <p>Staff are made aware of new infections through daily handovers on each shift, progress notes and clinical records. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use.</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>The ICN is responsible for implementing the infection prevention and control programme (IPC) and is supported by the CSM. The CSM has completed infection control training. The ICN is newly employed by the facility and it is planned that they will complete the MOH online training in the near future.</p> <p>There are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's quality and staff meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the</p>

		infection prevention and control programme.
<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>Dalcam Healthcare has documented policies and procedures in place that reflect current legislation and best practice relating to infection prevention and control.</p> <p>Staff observed were complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions.</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>All staff attend infection prevention and control training. Staff education on infection prevention and control is provided at orientation and at the quality and staff meetings. Caregivers and RNs receive further training from the CSM, CTL and external infection control specialists. Records of attendance are maintained. Staff interviewed confirmed that education on infection prevention and control is provided.</p> <p>Education with residents occurs on a one-to-one basis and includes reminders about hand washing, remaining in their room if they are unwell, increasing fluids during hot weather and Covid19. Information regarding infection prevention and covid19 is displayed on the notice boards. Staff receive notifications and updates about infection control via noticeboards, meetings and at handovers.</p>
<p>Standard 3.5: Surveillance</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>	FA	<p>The Dalcam Healthcare surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed.</p> <p>The clinical team leader is responsible for the surveillance programme at present as the designated ICN is newly employed.</p> <p>Infection control surveillance occurs monthly with analysis of data and reporting at staff and quality meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infections.</p> <p>In interview staff reported they are made aware of infections through handovers; progress</p>

		<p>notes; short term care plans and verbal feedback from the RN and the CTL.</p> <p>New infections and any required management plan are part of the handover, to ensure early intervention occurs. Families are updated by phone, email or text if required. Short term care plans are developed to guide care and evaluate treatment for all residents who have an infection.</p> <p>There have been no outbreaks since the last audit.</p> <p>Covid-19 information is available to all visitors to the facility. MOH information was available on site. Infection prevention and control resources were available should a resident infection or outbreak occur.</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 restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. The service demonstrates that the use of restraint is actively minimised. On the day of the audit, no residents were using restraints or enablers. The clinical team leader is the restraint co-ordinator and has completed training for the role.</p> <p>The residents are free to wander round the gardens. (Refer 1.4.7) There are no locked doors and residents can enter or leave the building as they feel like. Interviews with staff, residents and their family members confirm physical restraint and enablers are not being used in the facility.</p> <p>The two residents assessed as requiring rest home care requested to stay at the facility after rest home level of care changed to dementia level of care. These residents have consented to being cared for in a designated secure unit as they did not want to leave the facility. Review of these residents' files evidenced written consent records, requesting their desire to stay at the facility despite it being secure.</p> <p>Documentation, observations and interviews verified rest home residents have the means to independently exit the unit at any time and the provider does not intentionally restrict the residents' normal access to the environment.</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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	<p>PA Moderate</p>	<p>Neurological observations were recorded for unwitnessed falls however the falls management policy does not describe for how long neurological observations should be recorded following a fall. Interview with staff and review of documentation evidenced that the neurological observations were recorded every half an hour for one hour, hourly for two hours and two hourly for two hours for a total of seven hours.</p>	<p>The Dalcam Healthcare falls risk policy does not provide clarity and guidance for completing neurological observations following an unwitnessed fall. Neurological observation recording following an unwitnessed fall does not comply with best practice.</p>	<p>Ensure that the falls risk policy provides guidance on recording neurological observations following an unwitnessed fall in accordance with best practice.</p> <p>30 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and</p>	<p>PA Low</p>	<p>There is a Dalcam Healthcare documented infection control programme, however, the programme is not site specific to Westella Homestead and is not reviewed annually.</p>	<p>The infection control plan is not site specific and is not renewed annually.</p>	<p>Ensure the infection prevention and control plan is site specific and</p>

documented infection control programme that is reviewed at least annually.				reviewed annually 90 days
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.