New Certificate

Introduction

This report records the results of a Provisional 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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Many Hands Limited

Premises audited: Cornwall Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 17 July 2018 End date: 18 July 2018

Proposed changes to current services (if any): Cornwall Rest Home requires a provisional audit due to the pending sale of the facility.

Total beds occupied across all premises included in the audit on the first day of the audit: 26

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.

General overview of the audit

Cornwall Rest Home can provide care for up to 27 residents. Occupancy at the time of the on-site audit was 26 residents. This provisional audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff, the general practitioner, a nurse practitioner, current owner/manager, the co-owner/maintenance person and the prospective provider. The owner/manager is responsible for the overall management of the facility and is supported by the owner/maintenance person. Clinical services are overseen by the full time registered nurse with support from the owner/manager.

Following the change of ownership, two directors will form the governing body. The managing director will be responsible for the overall management. The registered nurse will continue to have oversight of clinical services.

Staffing is stable with minimal turnover. Staff hours are increased if required to meet the needs of residents. Residents and family interviewed provide positive feedback on the care provided.

There are improvements required in relation to policies, unobserved falls, self-administration of medicines and systems for informing the cook about nutritional needs.

Consumer rights

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 are accessible and discussed with residents and their families on admission to the facility.

Residents and family members confirmed their rights are met, staff are respectful of their needs and communication is appropriate.

Residents and family interviewed confirmed that informed consent is discussed and consent forms are provided. Staff members confirmed that time is provided if any discussions and explanations are required. Advance directives are completed by those deemed competent to complete these.

The owner/manager is responsible for management of complaints and managing director will be responsible for the management of complaint after the change of ownership. The service has a documented complaints management system and a complaints register is maintained.

Organisational management

There have been no changes within the organisational structure since the previous audit. The owner/manager has been in their position for 24 years and is suitably experienced for the role, supported by the co-owner/maintenance person. The owners are supported by a full time registered nurse who is responsible for clinical services and has been in the role for around three and a half

years. The registered nurse has been working in various roles at the facility, for almost thirteen years. A second registered nurse has been working part time at the facility for more than five years, supporting the full-time registered nurse.

Cornwall Rest Home has a documented quality and risk management system that supports the business management and provision of clinical care. There is a management system to manage residents' records with a document control process in place. Quality and risk performance is reported through meetings at the facility and is monitored. The quality programme includes an internal audit programme, an education and training plan, meetings, incident and accident monitoring, complaints management, management of infection control, restraint and health and safety.

There are human resource policies and procedures to guide practice. Validation of annual practising certificates for personnel who require them to practise is occurring. Staff records reviewed provide evidence that their human resources processes are followed. In-service education is provided for staff, including compulsory training around clinical service delivery. Review of staff records provides evidence that human resource processes are being followed.

Staffing levels are adequate and rosters meet residents' numbers and levels of acuity in the facility. Staff, residents and family confirmed that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents according to their individual needs. Staff turnover is low.

Registered nurses are on duty Monday to Friday, eight hours per day and after hours on call when the manager is not available. All staff have current first aid certification. Senior caregivers are responsible for the management of care over weekends.

The provisional audit confirmed that the prospective providers will keep the reporting processes to the governing body the same when directorship changes. The managing director stated they will manage financial decisions. Quality and risk management, adverse event reporting and service provider availability will continue and there are no current plans to change any of the current roles, except for the current owners being replaced by the new directors.

Continuum of service delivery

Residents receive services from suitably experienced and qualified staff. The initial assessments, the initial care plans and the short-term care plans for acute conditions are conducted within the required timeframes. Nursing care plan evaluations are documented, resident-focused and indicate progress towards meeting the residents' desired outcomes. The residents and family members have an opportunity to contribute to care plans and evaluations of care.

Activities are planned and appropriate to the group setting. The residents and families interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Residents' referrals and exit from the service are conducted according to policy with all the required information provided to the health service.

The medicine management system is documented and implemented to provide safe processes for prescribing, administration and medication reconciliation, dispensing, storage and disposal of medicines. Medicine management training is provided. The medicines policy includes a section on the self-administration of medicines.

Food and nutritional needs of residents are provided for in line with recognised nutritional guidelines. There is a central kitchen and on-site staff that provide the food service. All kitchen staff complete food safety training.

Safe and appropriate environment

There is a current building warrant of fitness and New Zealand Fire Service evacuation scheme in place. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings, and floor and wall surfaces are made of accepted materials for this environment.

All rooms provide single accommodation. There are no rooms with ensuite bathroom facilities, however, five rooms include a toilet with handbasin. All rooms except one have their own handbasin. Communal bathroom and showering facilities are provided throughout the facility and easily accessible.

Residents' rooms are spacious enough to allow for the safe use of mobility aids and staff. There are two lounges and three dining areas with decks and garden areas providing seating and shade.

There are policies and procedures for waste management, cleaning, laundry and emergency management processes. Staff are familiar with requirements around their roles. Staff receive training to ensure safe and appropriate handling of waste and hazardous substances.

Visual inspection provided evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is worn. Staff have completed appropriate training in chemical safety. All laundry processes are provided on site. Cleaning and laundry systems include appropriate monitoring systems through the internal audit process.

Essential emergency and security systems are in place with six-monthly fire drills completed. Call bells allow residents to access help, when needed, in a timely manner. The security system includes nightly rounds by a security service to ensure resident safety.

The provisional audit confirmed that the prospective providers do not currently plan to implement any environmental changes to the service.

Restraint minimisation and safe practice

Restraint minimisation policy and procedures and the definitions of restraint and enablers are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

There were no residents using restraint or enablers at the time of audit.

Infection prevention and control

The service provides an environment which minimises the risk of infections to residents, staff and visitors. Specialist infection prevention and control advice can be accessed from the district health board; microbiologist, general practitioners and infection control specialists if needed.

New employees are provided with training on infection control practices and there is ongoing infection control education available for all staff. Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and procedures and supported with staff education.

Aged residential care specific infection surveillance is undertaken, analysed, trended and results are reported to management and staff.

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	41	0	2	2	0	0
Criteria	0	89	0	2	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Care staff were observed interacting respectfully and communicating appropriately with residents. Staff receive training in the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights' (the Code) at least annually as confirmed in records sighted. Education relating to the Code occurs, including the complaints process. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, providing choices, encouraging independence and ensuring residents can continue to practise their own personal values and beliefs. Residents and family members were able to verify that services are provided with dignity and respect, privacy is maintained, and individual needs and rights are upheld.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice	FA	Residents' files identified that informed consent is obtained. Staff confirmed their understanding of informed consent processes.

are provided with the information they need to make informed choices and give informed consent.		There is an informed consent policy and procedure to guide staff in relation to gathering of informed consent. The policy and procedure include guidelines for consent for resuscitation/advance directives. Resuscitation orders are completed for residents where applicable. The service information booklet provided to new residents, includes information regarding informed consent. The owner and the RN discuss informed consent processes with residents and their families during the admission process. Residents and/or their EPOA sign an admission agreement on entry to the service. Review of resident files confirms that advance directives and consent for 'not for resuscitation,' where applicable, are appropriately documented and signed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There are policies regarding advocacy and support services in place. Information on advocacy services through the Health and Disability Commissioner's Office is provided to residents and families on admission. The role of advocacy services is included in training on the Code which is provided annually to staff. Residents and family interviews confirmed that advocacy support is available to them if required, including information on how to access a Health and Disability advocate. Resident information around advocacy services is included in the information booklet given to new residents and/or family. Resident files included information on residents' family/whānau and their chosen social networks. Staff training on the role of advocacy services is included in training on The Code. Discussions with families and residents identified that the service provides opportunities for the family and the EPOA to be involved in decision making processes.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau	FA	The service has an open visiting policy and residents may have visitors of their choice at any time. Visitors can access the facility to visit after the doors are locked using the bell at the entrance. Families confirmed they could visit at any time and are made to feel welcome.

and their community.		Residents, including YPD, are encouraged to be involved in community activities. Residents' files reviewed and handover demonstrated that progress notes and the content of care plans include evidence of residents attending t appointments in the community. Residents confirmed involvement with family and friends in the community. The YPD resident confirmed that they are supported to remain engaged in the community and they continue to engage in activities specific to their needs.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available in the lounge should anyone need access to a complaint form. The complaints register is in place and the register includes: the name of the complainant, the name of the person receiving the complaint, what the complaint is about, the date of complaint, the date of when action was taken, whether advocacy processes were commenced and when the complaint is closed out. Evidence relating to the lodged complaint is held in the complaints register. The last written complaint documented in the complaints register was from 2015. Review of the complaint showed it was investigated promptly and the issue resolved in a timely manner. Staff, residents and family confirmed they knew the complaints process. Due to the last recorded complaint having been in 2015, additional interviews with residents and their families in relation to complaints management, confirmed they discuss any concerns with the owner/manager or the RN and these are resolved at the time of discussion. There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the surveillance audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The owner/manager and the registered nurses (RN) discuss the Code with residents and their family during the admission process.

		Resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. The posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English. The completed resident and family surveys indicated residents are aware of their rights and are satisfied with this aspect of service delivery. Residents interviewed confirmed they had access to an advocate when needed. Families and residents are informed of the range of services including information included in the service and admission agreements. For the provisional audit the prospective provider confirmed their understanding of consumer rights and their previous experience working in disability services, implementing and maintaining consumer rights. This was confirmed during interview of the prospective provider.
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 policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour of residents. The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. The initial and ongoing assessments obtain details of people's beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated. The service ensures that each resident has the right to privacy and dignity. The residents' personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings. Caregivers reported that they knock on bedroom doors prior to entering

		rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families confirm that residents' privacy is respected. The owner/manager and the RN confirmed their commitment to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training on abuse and neglect. There are no documented incidents of abuse or neglect. Residents, staff, family and the nurse practitioner (NP) confirmed that there is no evidence of abuse or neglect. Staff interviewed were aware of the need for them to ensure residents are not exploited, neglected or abused and they can describe the processes for escalating issues. Resident files reviewed, including files for young persons with disabilities (YPD), confirmed that cultural and/or spiritual values and individual preferences are identified.
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 organisation has a cultural policy which outlines the processes for working with people from other cultures and procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged and there are processes in place to ensure residents who identify as Māori, have access to appropriate services. The Māori health plan includes the principals of the Treaty of Waitangi, partnership, participation and protection, and the holistic view of Māori health is incorporated into the service delivery through care planning. Cultural needs are identified in the residents' care plans. Cultural training for staff is provided as part of the annual training programme. Caregivers confirmed an understanding of cultural safety in relation to care. The activities officer completes cultural assessments on admission and reviews activity plans six monthly. Staff are aware of the importance of family/whānau in the delivery of care for the Māori residents. There were two residents identifying as Māori living at the facility at the time of the on-site audit. Residents have access to Māori support and advocacy services if required, as

		confirmed during interviews.
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 identifies each resident's personal needs from the time of admission. Information gathered during assessments on admission includes the resident's cultural values and beliefs. There is a culture of choice with the resident determining when cares occur, times for meals and choices in meals and activities. Residents' files reviewed demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whānau contact details. Residents interviewed confirmed their spiritual needs are met. Residents and family are involved in the assessment and the care planning processes. Information obtained is included in the care plan. Caregivers confirmed an understanding of cultural safety in relation to care.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility implements policies and processes to ensure staff are aware of the requirement for good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Interviews confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. Staff training includes discussion of the staff code of conduct and prevention of inappropriate care. Residents and family stated that they would formally complain to management if they felt that they were discriminated against. There were no complaints relating to any form of discrimination. Job descriptions include the responsibilities of position including ethical issues relevant to the role. Staff complete orientation and induction which includes recognition of discrimination, abuse and neglect. The orientation programme and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the

		boundaries of the caregivers' role and responsibilities. Registered nurses confirmed their understanding of what is expected under the code of conduct and professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Staff interviews described sound practices based on policies and procedures, care plans and information given to them about care. Staff have access to information on good practice provided by governing bodies and specialists in the Wairarapa District Health Board. There is a training programme for all staff and RNs are encouraged to complete training provided by the district health board (DHB). Registered nurses have access to specialist educators as part of the in-service education programme. Policy is not consistently aligned with current practice (refer to 1.2.3.3). Residents and families interviewed expressed a high level of satisfaction with the care delivered. The level of satisfaction was also expressed in annual satisfaction surveys of February 2018. The nurse practitioner interviewed expressed satisfaction with the clinical oversight and care provided. Consultation is available through an independent consultant when needed.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Accident and incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family or the enduring power of attorney of any accident or incident that occurs. The service has policies and procedures in place to guide staff on full and frank open disclosure. Processes are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed provided evidence that communication with family members is documented. There was evidence of communication with the residents' general practitioners (GP) and the NP. Interview with YPD confirmed they are satisfied with how the service providers communicate.

		Interviews with family members confirmed they are kept informed. Family also confirmed that they are invited to the care planning meetings for their family member and could attend the resident meetings. The owner/manager confirmed they have access to alternative modes of communication, should this be required for YPD. Interpreting services are available from the DHB and/or family who are prepared to interpret for residents who require this in the service. There are no residents in the service for whom English is a second language. The service has several staff who speak other languages, including te reo Māori.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Two owners provide oversight of the service. One owner is designated as the owner/manager and the other is the owner/maintenance person. Both the owners were on site during the audit. The owner/manager was the key carer for close family members prior to starting the facility in 1994. The owner/manager is supported by the full time RN. There are monthly quality assurance meetings between the owners, the office manager and the full time RN. Meeting minutes are recorded and previous meeting minutes and reports are tabled at this meeting. The RN has been working at the facility for 13 years of which just over 3 years have been in the role of the RN. The second RN works on Mondays and has been working at the facility for more than five years and is working four days per week at another aged care facility. There is a philosophy, values and goals documented in the strategic and business plan for 2018. The strategic plan is reviewed annually with an annual report documented by the office manager. The report is tabled at the management meeting. The philosophy is communicated to residents, staff and family through the information booklet and staff receive orientation and training. The facility can provide care for up to 27 residents requiring rest home level of care. During the audit there were 26 residents living at the facility requiring rest home care, including a YPD, who confirmed the services meet their needs. The facility also holds contracts with the

		DHB to provide respite care, day care and long-term support for chronic health conditions specific to YPD. The prospective provider confirmed adopting the already established organisational structure, including governance, management and staffing, including key personnel and clinical roles. The new managing director has been a RN prior to working in clinical management roles and the chief executive officer of a disability service. The managing director stated that there will be a second director who will not initially have an active role in the management of the service, but will form part of the governing body. The agreement with the current owners is that the prospective provider will complete orientation and induction to the role with the lead-in time ending on 15 September, when the prospective provider intend to take over the facility with the managing director responsible for managing services, including finances. The current owners stated they will be available for consultation for another three months after the take-over. The prospective provider has developed a plan with timelines to ensure a smooth transition. The plan does not include any changes that may affect the service's capacity to meet the requirements of the Health and Disability Services Standards.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The service has appropriate systems in place to ensure the day-to-day operations of the service continues should the owner/manager be absent. The RN, with support from the office manager, stands in when the owners are absent. The prospective provider stated that the RN will continue to manage clinical services and this will be with the support of the prospective provider as the managing director. The prospective provider stated they will continue with current plans for service management, such as determining who will cover when rostered staff are absent and managing staff changes.
Standard 1.2.3: Quality And Risk Management Systems	PA Low	Cornwall Rest Home has a quality and risk management framework.

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		Most of the policies are aligned with the Health and Disability Sector Standards and are available to staff in hardcopy, however, not all policies are aligned with current good practice, legislation and guidelines or include references to current legislation or guidelines. New and revised policies are presented to staff to read and staff sign to say they have read and understood the policy. Staff interviewed stated they read new or revised policies. Staff interviewed reported they are kept informed of quality improvements. There are monthly joint staff, quality, health and safety, infection control and RN meetings. There are bimonthly resident meetings with opportunity for families to attend. Template agendas are used during meetings. Service delivery is monitored through review of complaints, review of incidents and accidents with monthly analysis of data, surveillance of infections, and implementation of an internal audit programme. Corrective action plans are documented. Risks are identified. There is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Resident/family satisfaction surveys are completed annually and show residents and families are satisfied with the levels of care they receive. Interview with the YPD confirmed participation in decision making, having access to technology and the equipment or aids they may need. The internal audit schedule and completed audits were reviewed. Clinical indicators and quality improvement data is recorded. Review of the quality improvement data provided evidence the data is being collected, collated, evaluated and analysed to identify trends and that this data is being reported on at the staff meetings and reported to the owners at monthly management meetings. There are health and safety manual documents health and safety management systems including a health and safety plan. There is evidence of health and safety management, internal audits, accident and incident reporting, injury management, hazard management and an emergency plan. Meeting minutes are reviewed by management and provided evidence of discussion and reporting on accident/ incidents; hazards; staff wellness programme, service objectives and

		maintenance. The prospective provider will continue with the current quality plan (2018), quality management systems, including schedules for internal audit, and other key quality indicators to ensure continuity of services and care.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	The owner/manager and RNs are aware of situations in which the service would need to report and notify statutory authorities, including: police attending the facility; unexpected deaths; sentinel events; infectious disease outbreaks and changes in key managers. There is evidence of open disclosure for recorded events. Staff receive education on the incident and accident process during orientation and as part of their ongoing training programme. Staff understood the importance of the adverse event reporting process and could describe recording of near misses. Information gathered around incidents and accidents is analysed with evidence of improvements put in place. Incident/accident forms are completed for the management of unplanned events. Incident/accident records were reviewed for unobserved falls and the documentation showed that investigation of falls occurred, however, there is no supporting evidence of neurological observations having been recorded for any of the unobserved fall or that reassessment occurred. There are no legislative compliance issues or concerns regarding the takeover of the prospective provider. The prospective provider stated that all quality indicators, including adverse event reporting will continue to be managed using the current management system.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Policies and procedures in relation to human resource management are available and implemented (refer to 1.2.3.3). Skills and knowledge required for each position is documented in job descriptions. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientations and

		induction records. All staff complete an orientation programme and caregivers are paired with a senior caregiver for shifts or until they demonstrate competency on a number of tasks, including personal cares. There is an appraisal process in place with staff files indicating that all have an annual appraisal completed. There is a low turnover of staff. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practise. Apart from medicines management competencies for RNs, all competencies were up to date (refer to 1.3.12.1). There is an in-service education and training programme ensuring staff are up to date in service delivery practices. Individual staff attendance records and attendance records for each education session were reviewed and evidenced that ongoing education is provided. The prospective provider intends to continue with the education and training programme of the current owners/management.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Staffing levels are reviewed for anticipated workloads, including numbers of residents and appropriate skill mix of staff, or as required due to changes in the services or resident needs. The staffing policy is the foundation for workforce planning. Rosters showed that staffing levels meet resident acuity and bed occupancy. There are 25 staff, including the owners/management team, RNs and household staff. There is a RN on each morning shift Monday to Friday. Registered nurses are available after hours on call when the manager is not available. Residents and family interviews confirmed staffing is adequate to meet the residents' needs. The prospective provider stated they will be taking over the current policies of the service and continue to use the policies for guiding service provision, this include the current skill mix policy and that current RN positions will continue.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	There are policies and procedures in place for privacy and confidentiality of residents' records. Staff described the procedures for maintaining confidentiality of residents' records. Resident care and support information can be accessed in a timely manner. Documents containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being locked away in an office. Archived records are securely stored and easily retrievable. All components of the residents' records reviewed include the resident's unique identifier. The service retains relevant and appropriate information to identify residents and track residents' records. This includes information collected on admission with the involvement of the family. The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Medication charts are kept separate from residents' files and are accessible by authorised personnel only. Residents' progress notes are completed on every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes identify the name and designation of the person making the entry.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Resident files sampled confirmed needs assessment and service coordination (NASC) assessments are completed for entry to the service. There are signed admission agreements. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's care requirements. An information pack is provided to all residents and their families. Residents and family members interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	FA	There is a policy that describes guidelines regarding documentation and follow-up for death, discharge or transfer. A record is kept and a

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		copy is kept on the resident's file. This was sighted in one resident file. All relevant information is documented and communicated to the receiving health provider or service via the yellow envelope system. Communication with the family is made and documented as required.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There are policies and processes that describe medication management (refer to 1.2.3.3). Medication areas evidenced a secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The drug register is maintained and evidenced weekly checks and six monthly physical stocktakes. A computerised medication management system is used at the facility and meets the current legislative requirements and safe practice guidelines. A safe system for medicine management and administration was observed. Residents' progress notes and electronic medication management system did not always document outcomes following administration of analgesic medicine. Residents' interviewed who had received analgesic medicines, reported they were assessed regularly for pain and they were happy with outcomes and the level of care provided. Staff completed education in medicine management, however, not all RNs who administer medicines had a current annual medication competency. The medicine's fridge temperature readings are documented within the recommended range. There is a policy and process that describes self-administered medicines. There are currently three residents who self-administer their medications, however, not all residents who self-administer medicines had current competencies documented.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met	PA Low	Food provision is overseen by the manager. The food service is provided on site. The kitchen and equipment are well maintained. All aspects of food procurement, production, preparation, storage,

where this service is a component of service delivery.		transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures are documented within accepted range. The kitchen staff have completed all relevant food safety training. The winter and summer menus are varied and developed by a dietitian. The menu was last reviewed by a dietitian in 2015. At interview, the cook reported that the RN completes each resident's nutritional profile on admission with the aid of the resident and family. The kitchen can cater to specific needs as requested and diets are modified as required. The service encourages residents to express their likes and dislikes. The system for informing the cook about all residents' dietary needs was not evidenced in the kitchen. Residents requiring extra support to eat and drink are assisted, this was observed during the on-site audit. The residents interviewed spoke highly about meals provided and they all stated that staff ask them about their food preferences.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	When a referral is received, but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC coordinator is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	A nursing assessment is completed within 24 hours of admission informs the initial care plan. Personal needs, outcomes and goals of residents are identified. Resident files sampled demonstrated that a range of assessment tools were completed in resident files including (but not limited to); falls, pressure areas and continence. All files sampled had a current interRAI assessment. Nutrition and pain are assessed on admission and as needed and weights and general observations are monitored on a weekly to monthly basis dependant on needs. Assessments are conducted in a private manner. Wound assessment and wound management plans were in place for two residents with wounds. All wounds are assessed, reviewed and managed within the stated timeframes. Photos and wound care plans

		document evidence of healing wounds. On interview, the RN stated that they could access the DHB wound or continence specialist nurse if required. Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Residents and families interviewed stated they were informed and involved in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate. All six care plans sampled were evidenced to be up to date. Goals and outcomes are identified and agreed. Delivery of care is explained. All files sampled have an individualised LTCP that covers all areas of need identified. Areas covered in the six resident files sampled include, but are not limited to, nutrition, elimination, activities of daily living, falls risk, specific medical needs, behaviour, and cultural, social and emotional needs. Long-term care plans demonstrated service integration.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The care being provided is consistent with residents' needs and desired outcomes. This is evidenced by review of documentation, observation and interviews with residents, family and staff. There is evidence of referrals to specialist services such as podiatry, physiotherapy, nutritional, district nurses and DHB nurse specialists. There is also evidence of community contact. Residents and family/whānau members expressed satisfaction with the care provided. There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.
Standard 1.3.7: Planned Activities	FA	Interviews with the activities officer and RN confirmed the residents' social assessments, including past activity/recreational history, are

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.		undertaken on admission to ascertain the residents' needs, interests, abilities and social requirements. The residents' activity needs are evaluated regularly and as part of the formal six-monthly care plan review. Residents' attendance and participation at activities are documented. Outcomes against goals are recorded. The activities reflect the residents' goals, ordinary patterns of life and include normal community activities. The activities are discussed at the residents' meetings and indicate residents' input is sought and responded to. Residents interviewed confirmed their satisfaction with the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the residents' progress notes. If any change is noted it is reported to the RN or the manager. Following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals, formal care plan evaluations occur every six months or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service responds by initiating changes to the LTCP. A short-term care plan initiated for short-term concerns, such as infections and wound care is evaluated and signed off once resolved or added to the LTCP. Interviews, verified residents and family/whānau are included and informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral forms and documentation are maintained on resident files. If the need for other non-urgent services are indicated or requested, the GP, NP or RN sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by GP, NP or RN. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.

Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Policies and procedures specify labelling requirements in line with legislation, including the requirements for labels to be clear, accessible to read and free from damage. Documented policies and procedures provide guidelines for staff in the management of waste and hazardous substances. Incidents and accidents are reported on in a timely manner. Material safety data sheets are available and accessible for staff. Staff receive training and education in safe and appropriate handling of waste and hazardous substances. The hazard register is current. Protective clothing and equipment that is appropriate to the recognised risks is provided. During a tour of the facility, protective clothing and equipment was observed in high-risk areas.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed. There have been no building modifications since the last audit. Interview with the owner/manager and the owner/maintenance person confirmed there is a planned and reactive maintenance schedule in place. The service has an up-to-date annual test and tag programme. Checks and calibrating of clinical equipment occur annually. Interviews with staff and observation of the facility confirmed there is adequate equipment and aids. Corridors are wide, providing space for residents, including resident using wheelchairs, to safely pass one another. The service provides mobility access throughout the facility, meeting requirements for YPD. There are quiet areas throughout the facility for residents and their visitors. There are decks, lawns and areas with shade and outdoor table and chairs. The prospective provider confirmed that they do not currently have any plans for environmental changes to the service.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	Visual checks provided evidence that toilet; shower and bathing facilities are adequate for the number of residents residing at the facility. Visitors' toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant. Equipment/accessories are made available to promote resident independence. Hot water temperatures are monitored at monthly intervals and is delivered in line with the recommended temperature range. Interviews with the owner/maintenance person confirmed that if the hot water temperatures exceed the recommended temperatures, a corrective action is taken to address the issue. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided in all bedrooms. All rooms provide single accommodation. Residents and staff can move around within the room safely. Residents interviewed all spoke positively about their rooms. In rooms requiring equipment there is sufficient space for both the equipment, for example, a hoist and at least two staff and the resident, with the ability to include emergency equipment in the room, if required. Rooms are personalised with furnishings, photos and other personal adornments. The service encourages residents to make the suite their own. There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The service has several lounge/dining areas, including an area that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.

		The dining area has sufficient space for residents. Residents can choose to have their meals in their room. There are places within communal areas of the facility where YPD residents can privately meet with friends and family.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry services are completed on-site. There are processes in place for daily collection, transportation and delivery residents' personal clothing to their rooms. The effectiveness of the cleaning and laundry services is audited as part of the internal audit programme. There is a cleaner on site during the day, seven days a week. The cleaner has a trolley for chemicals. The cleaner is aware that the trolley must be with them at all times. The interview with the cleaner confirmed they have specific guidelines to ensure appropriate cleaning processes. There are safe and secure storage areas for chemicals and cleaning products. Staff have appropriate and adequate access to these areas, as required. Chemicals are labelled and stored safely within these areas. Staff receive training around the use of products. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility but for one room, which is closely situated to the bathroom. Residents and families stated they were satisfied with the cleaning service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The service has documented systems in place for essential, emergency and security services. All staff are required to complete first aid training. Emergency and security management education is provided at orientation and at the in-service education programme. Staff records sampled provided evidence of current training regarding fire, emergency and security education. Security systems include security processes to ensure all entrances

		are locked after dark. A local security company completes two security rounds per night. Staff complete security checks at set intervals. Families and residents, including YPD, know the process of alerting staff when in need of access to the facility after hours. Information in relation to emergency and security situations is available/displayed for staff and residents. Emergency equipment is accessible, current and stored appropriately with evidence of emergency lighting, torches, gas and barbeque for cooking, extra food supplies, emergency water and blankets. The service has a call bell system in place that is used by the residents, family and staff members to summon assistance. All residents have access to a call bell. Call bells are checked monthly by the maintenance person and is audited for effectiveness. Residents confirmed they have a call bell and staff respond to it in a timely manner. There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service. Visitors and contractors are required to sign in and out of visitors' registers.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Families and residents confirmed that rooms are maintained at an appropriate temperature. There are designated smoking areas for the staff and residents.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The full time RN is the infection control nurse (ICN) and has a job description for this position. The infection control policies and procedures clearly define the lines of accountability and responsibilities for infection control matters in the facility. The ICN is aware of processes for the required notification of infection control related issues. There is evidence of regular reports on infection related issues

		and these are communicated to staff and management. The infection control programme is reviewed annually. Visual information is located throughout the facility for visitors, staff and residents' awareness of infection control procedures to minimise the risk of infection. Staff confirmed in interview they were aware not to come to work if they were suspected or suffering from infections. On audit days there was evidence of prompt action for a resident requiring isolation.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICN has the required knowledge and experience in infection control matters. Expert advice is sought through the GPs, NP, microbiologist and the DHB infection control team. Interviewed staff reported that infection control issues are discussed at the facility's meetings. The ICN and the manager have access to records and diagnostic results of residents. The residents' files evidenced flu vaccines were conducted and signed consent forms were sighted. Implementation of the infection control programme is monitored via: the internal audits; staff education and training; and infection control documentation.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control policies and procedures manual provide information and resources to inform staff on infection prevention and control. The policies and procedures comply with relevant legislation and current accepted good practice and are reviewed regularly. On the audit days, staff were observed performing hand hygiene and using required products for infection control. Interviewed staff reported that there are adequate infection control resources and equipment for use. Adequate quantities of personal protective equipment were sighted on audit days. Interviewed staff demonstrated awareness of infection control procedures.

Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICN attends relevant infection control training. The infection control training for staff is conducted by the ICN. Staff training records were sighted and confirmed this. Individual resident infection control education is conducted per rising need in a manner that recognises and meets the residents' communication method, style and preference. Interviewed staff reported that infection control is part of staff orientation for all staff and ongoing education is provided.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance for infection control is completed as specified in the infection control programme. The type of surveillance carried out is suitable to the type of service provided and the size of this facility. Standardised definitions are used for identification and classification of infection events, indicators or outcomes. Infections are collated monthly, including urinary tract, upper respiratory and skin. This data is analysed for trends and reported to the quality meetings and to the monthly staff meetings. Interventions are evaluated regularly on short-term care plans and signed off when infection is resolved. Interviewed staff demonstrated awareness of infection statistics and interventions in place to manage the infections. Interviews and review of infection control records evidenced a norovirus outbreak in July 2017 had been managed well. Regional Public Health was informed and involved where necessary.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service philosophy which promotes a restraint free environment. The policy incudes the definition of restraint and enabler which is congruent with the definition in the standard. There were no residents at the facility using enablers or restraint on the days of the audit. Staff and management interviews confirmed the approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

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 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.	PA Low	The document review prior to the audit identified that some of the policies were not reviewed within the previous two years. These documents were reviewed on-site confirming all policies have been reviewed prior to the audit. Review of policies showed that very few policies refer to current legislation or guidelines. The human resource policies and medicines management policies do not include all the information specific to Cornwall Rest Home’s practices. Although the providers practice around human resource management is sound, the policy does not reflect their practice, for example; that new employees are provided with job descriptions, there are expectations in relation to a code of conduct, the content of employment agreements, completion of	i) Policies do not all include reference to applicable legislation and guidelines. ii) Policies are not all specific to the practice of the provider.	i) Policies to include reference to applicable legislation and guidelines. ii) Policies to be specific to the practice of the provider, therefore guiding service provision. 180 days

		referee checks, police check requirements, use interview questionnaires, or expectations in relation to competencies, including first aid training. The medicines management policy does not reflect the services' current practice, including the requirements around competencies, requirements around self-administration of medicines and other requirements as specified in relevant legislation and guidelines.		
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Ten incident/accident records were reviewed related to unobserved falls. Incidents/accident records include evidence of investigation of falls, information about informing family and, where required, informing the GP. Sign-off of incidents and accidents investigations are completed by the RN, however, best practice would require the owner/manager to also sign off in evidence of changes having been implemented. None of the incident/accident records reviewed showed evidence of neurological observations being completed or reassessment of the resident having occurred. Incident/accident records are not consistently completed for all wounds.	i) The owner/manager does not sign off incident/accident records in evidence of corrective actions/quality management processes having been implemented. ii) Neurological observations and reassessment of residents who have unobserved falls are not completed. iii) Not all wounds are reported or investigated using the incident/accident reporting process.	i) The owner/manager to sign off incident accident records in evidence of corrective actions/quality management processes having been implemented. ii) Neurological observations and reassessment of residents who have unobserved falls to be completed. iii) All wounds to be reported and investigated using the incident/accident reporting process. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and	PA Moderate	Residents' who request to self-administer medicines are provided with secure storage for their medicines. An initial assessment to verify the resident's safety and competency to administer medicines is completed.	i) Residents who self-administer medicines do not all have current competencies completed.	i) All residents who self-administer medicines to have current competencies completed.

appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		However, an ongoing assessment was sighted to be conducted four-monthly for two of three residents who are self-administering their medicines. All observed medications administered are signed for in accordance with the required legislation and guidelines. Two residents who had analgesic medication administered did not have documented evidence of effectiveness of analgesia given. Registered nurses complete medication education and competencies, however, not all medication competencies for RNs are documented annually.	ii) Residents requiring analgesia do not have documented outcomes consistently recorded. iii) Annual medicines competencies for staff administering medicines have not been documented within the last twelve months.	ii) Effectiveness of analgesics to be recorded. iii) Staff administering medicines to complete medicines management competencies annually. 90 days
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Low	A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal preferences, any special diets and modified texture requirements are made known verbally to kitchen staff and accommodated in the daily meal plan.	The system for informing the cook of nutritional needs is not currently evidenced.	The facility to have a documented system whereby the cook is informed of special needs/preferences relating to nutrition. 90 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

No data to display

End of the report.