

Summerset Care Limited - Summerset By The Lake

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset by the Lake
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 November 2018 End date: 30 November 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	14

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	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
Red	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

Summerset by the Lake provides rest home level care for up to 19 residents across serviced apartments. On the day of the audit there were 14 residents receiving rest home level care.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, management and staff. The village manager is an experienced registered nurse and supported by a clinical leader (registered nurse) who oversees the clinical services.

Summerset by the Lake has a site-specific business plan 2018, which is implemented and reviewed regularly throughout the year. The service continued to implement their quality and risk management system. The residents and relatives interviewed spoke positively about the care and support provided.

This audit identified improvements required around resident's self-medication and timeframe.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and families are kept informed on all aspects of the service and resident health. Residents and their family are provided with information on the complaints process on admission. Complaints are managed by the village manager. An electronic complaint register is maintained, which includes care centre and the village related complaints.

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.
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Summerset by the Lake continue to implement their quality and risk management system. Annual surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service.

Staff training and development programme is implemented. The service has an orientation programme that provides new staff with relevant information for safe work practice.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Appropriate employment policies are documented and annual staff appraisals have been completed. The roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Each stage of service delivery is facilitated by the clinical leader and the registered nurse. Service uses an electronic resident management system. Risk assessment tools and monitoring forms were available and implemented. Resident's care plans were individualised and comprehensive.

A recreational therapist implements activity programme. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and visiting entertainers.

The service uses electronic medication management system. Staff who are responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three-monthly.

The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Residents interviewed responded favourably about the food provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are documented policies and procedures around restraint use and use of enablers. There were no restraints or enablers in use on the day of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The clinical leader is the infection control officer who collates information obtained through surveillance activities to determine infection control activities and education needs in the facility. Infection control surveillance were undertaken by the clinical leader. Trends are identified and analysed, and preventative measures are put in place. Summerset by the Lake maintains low infection rates.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	0	0	0
Criteria	0	39	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<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>Complaints are managed by the village manager. An electronic complaint register is maintained, which includes care centre and the village related complaints. There was one complaint about the care centre related to an environmental issue. The complaint was investigated and followed up by the management. Outcome of the complaint was noted and discussed at the quality improvement and management meetings.</p> <p>Where appropriate surveys or internal auditing is completed as part of the monitoring process. The 2017 consumer survey identified 99% satisfaction. Compliments and suggestion forms are available for residents and families. Seven staff (one registered nurse (RN), three caregivers, one recreational therapist, one chef and one kitchen assistant) interviewed are knowledgeable in the complaints and concerns process. Residents and family interviews confirmed that they were provided with information on complaints and complaints forms, and are comfortable approaching management with any concerns/complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Open disclosure principles are implemented, and the service maintains regular contact with residents and families. The village manager has an open-door policy. The village manager talks weekly with residents in a group and resident meetings are held three-monthly. An advocate from Age Concern runs the meetings and visits the site regularly.</p> <p>Five residents and three family members interviewed confirmed that they are informed of changes in the health</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>status of residents and incidents/accidents. Eight incident and accident forms reviewed showed family contact following the unexpected events.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>The service has policies and procedures available for access to interpreter services for residents (and their family/whanau). If residents or family/whanau have difficulty with written or spoken English, the interpreter services are made available.</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>Summerset by the Lake is certified to provide rest home level care for up to 18 residents in serviced care apartments. An additional room with ensuite is utilised for respite care. On the day of the audit, there were 13 rest home residents in the care apartments and one resident in the respite room under long-term care. All residents were under the Aged Related Residential Care (ARRC) contract.</p> <p>The service provides home based services to clients in the care apartments and the village. There were four residents in the service apartments receiving packages of care. Summerset by the Lake has a site-specific business plan 2018, which is implemented and reviewed regularly throughout the year.</p> <p>The village manager is an experienced business manager and registered nurse with a current practicing certificate. She has attended two-day Summerset manager's forum.</p> <p>The village manager is supported by a clinical leader who has been in the position since January 2018. There is a regional operations manager who is available to support the facility.</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>Summerset by the Lake continued to implement the organisation's quality and risk management system.</p> <p>There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the village manager completes a 'best practice' sheet confirming completion of requirements. The best practice sheet reports (but is not limited to): meetings held, induction/orientation, audits, competencies and projects and is forwarded to head office as part of the ongoing monitoring programme. A resident satisfaction survey was completed in 2018 but survey results were not analysed yet. The 2017 survey results showed a high overall satisfaction rate of 98%. Corrective action plan showed that issues and comments were identified, and actions taken to address those. The 2018 survey is</p>

		<p>awaiting analysis.</p> <p>There is a meeting schedule, including monthly quality improvement meetings, that includes discussion about clinical indicators (e.g., incident trends, health and safety and infection rates). Management meetings are held weekly, health and safety /IC three-monthly. Care staff meetings also take place to discuss clinical and facility wide issues and updates.</p> <p>The internal audit programme is implemented and includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. There are monthly accident/incident and infection control reports.</p> <p>Summerset has a data tool "Sway - the Summerset Way". Sway is integrated and accommodates the data entered. There is a health and safety and risk management programme in place including policies to guide practice. Hazard register is reviewed and up to date. Health and safety is well imbedded in to the quality management system. There is a site-specific health and safety plan/award, encouraging employee participation in health and safety hazards. Near miss's data entered into Sway, sharing of health and safety information and actively encourage staff input and feedback. Seven staff and management (the village manager, the clinical leader and regional quality manager) interviewed stated that one staff member received the Summerset National Caregiver Award. Staff health, positive engagement and staff retention was priority for Summerset by the Lake and there were a number of activities and support provided to staff to achieve national and site-specific goals.</p> <p>Summerset by the Lake ensures that all new staff and any contractors are inducted to the health and safety programme. The health and safety programme has been designed around the new legislation. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of</p>	<p>FA</p>	<p>Incident and accident data is being collected and analysed. Eight incident/accident forms for the period of September to November 2018 were reviewed. They were all fully completed, including follow-up by a RN and relative notification. Post falls assessments were completed including neurological observations for two unwitnessed falls with potential head injury. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. Falls with injury and without injury data is graphed and posted on the notice board in the staff room. Falls data was reviewed, and outcome of this review was communicated to staff.</p> <p>Discussions with the village manager and the clinical leader confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications completed since the previous audit.</p>

choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies are being implemented. Six staff files (one clinical leader, one RN, one recreational therapist and three caregivers) were reviewed, and all had relevant documentation relating to employment. Annual performance appraisals for staff have been completed. The RN practising certificates were kept in the file and these were current.</p> <p>An orientation programme is implemented, and completed records are maintained in the staff files. Staff interviewed could describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>An annual training programme is being implemented and attendance records maintained. The clinical leader and the RN are both interRAI trained.</p> <p>Staff complete competencies relevant to their roles, and staff interview confirmed that they were competent to undertake their role.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Staffing rosters were sighted and there is adequate numbers of staff on duty to meet the resident's needs on different shifts.</p> <p>The village manager works 40 hours per week Monday to Friday and is available on call for any emergency issues or clinical support. The clinical leader works full time Sunday to Thursday and she also provides on call cover. There is another RN who works two to three days a week. The caregivers interviewed confirmed that staff are replaced when off sick.</p> <p>There are two care staff on duty for mornings, afternoons and night shift. Home-based support services are provided by one of the staff on duty allocated to the personal cares. There is at least two staff members on duty in the care centre at all times. Residents and family members stated advised that they felt there was sufficient staffing. Staff interviewed stated that they are busy at times. There is one home care assistant who works 8-10.30 am five times a week, and there are office support staff gardener, property maintenance staff and a recreation therapist support delivery of services to residents at Summerset by the Lake.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p>	PA Low	<p>The service uses an electronic medication system. The medications are administered by competent caregivers, the RN or the clinical leader. Staff who administer medication have completed annual medication competencies and education. All medications are checked on delivery, any discrepancies fed back to the supplying pharmacy.</p> <p>Ten medication charts were reviewed. The medications are reviewed at least three monthly by the GP. There</p>

<p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>were photo identification and allergy status recorded. 'As required' medications had indications for use prescribed. Effectiveness of pain management and PRN medication is recorded on the electronic system. The service facilitates self-medication administration, and one resident currently self-medicates but the process was not fully implemented.</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>The facility uses a contracted company for food service. Food is prepared and cooked on site for the care centre residents, and the village residents upon request. There is a well-equipped kitchen and special equipment such as lipped plates, straws are available. Staff were observed wearing correct personal protective clothing. On the day of audit meals were observed to be hot and well-presented, and residents stated that they were enjoying their meal.</p> <p>Kitchen fridge and freezer temperatures are being monitored and recorded. Food temperatures are checked, and these were all within safe limits. A cleaning schedule is implemented. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen.</p> <p>The current menu was audited by the Summerset dietitian in February 2018, and recommendations has been actioned. The food control plan was approved by the local city council dated June 2019. All residents and family members interviewed were satisfied with the meals. Residents have the opportunity to feedback on the service through resident meetings and surveys. The latest survey showed positive comments around food services.</p> <p>The service also has a café which was run by the same contracted provider. Care centre and village residents and visitors are able to purchase food from the café.</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>Documentation reviewed and interviews with staff, residents and relatives identified that the care being provided is consistent with the needs of residents.</p> <p>When a resident's condition changes, the clinical leader initiates a review and if required, a GP or nurse specialist consultation. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents and medication changes. Residents interviewed stated that their needs are being met.</p> <p>Adequate dressing supplies were sighted. There were no wounds on the day of audit. Two files reviewed had records of previous minor wounds. These were appropriately managed. The clinical leader confirmed that there is access to a wound care specialist through local DHB.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is</p>

		<p>available as needed.</p> <p>There are a number of monitoring forms and charts available for use including (but not limited to): pain monitoring; blood sugar levels; weight; food and fluid intake; and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A recreational therapist (RT) provides activities for Monday to Friday, 15 hours a week. She has been with the service for two years. Volunteers are also involved in the programme. There is another RT who provides activities for the village, and she provides cover when care centre RT is on leave.</p> <p>There is monthly programme includes several community connections. Residents have an activities/social profile assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, and family. Activities are age appropriate and planned. The programmes running for residents are meaningful and reflect ordinary patterns of life.</p> <p>Residents provide regular feedback around their likes and dislikes of the activity programme following activities or through residents' meetings. There are monthly resident meetings, and quarterly meetings are held with the Age Concern advocate.</p> <p>Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed. On the first day of audit, residents were observed being actively involved with a variety of activities in the care centre and community outings occurred on the second day of the audit. Three residents returned from outings stated that the trip was very enjoyable and confirmed active community involvement.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>There is evidence of resident and family involvement on entry to the service during assessment process, in the development and review of resident s' care plans. Written evaluations were completed six-monthly or earlier for resident health changes in four out of five files reviewed. One resident had not been at the service six months. There is multidisciplinary team involvement in the reviews including input from the GP and any allied health professionals involved in the resident's care. Families interviewed stated that they were asked for input in care plan reviews. Short-term care plans sighted have been evaluated by the RN. The GP completes three-monthly reviews.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	FA	<p>The building warrant of fitness is current. Reactive and preventative maintenance is maintained.</p>

appropriate, accessible physical environment and facilities that are fit for their purpose.		
<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>There is a policy describing surveillance methodology for monitoring of infections. The clinical leader is the infection control officer who collates information obtained through surveillance activities to determine infection control activities and education needs in the facility. Infection control data, including trends, is discussed at the quality improvement, health and safety and management meetings. Meeting minutes including graphs are available to staff on noticeboards. Trends are identified and analysed, and preventative measures are put in place.</p> <p>There are clear lines of accountability to report to the village manager on any infection control issues. All staff complete infection control education on orientation and annually as part of the education planner.</p> <p>Review of the quality data showed low infection rates. There were no skin and urinary tract infections since March 2018 and no respiratory tract infection since August 2018.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. The RN is the restraint coordinator. The service currently has no resident assessed as requiring the use of restraint or an enabler. Staff receive training around restraint minimisation that includes annual competency assessments.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	Ten medication charts were reviewed. The GP had reviewed the medication charts three monthly. One resident was initially admitted to the service under respite care then later on, admitted as a long-term care resident. The residents were assessed by the GP as competent to self-medicate, but the resident did not have a medication chart or current pharmacy medication list. Self-medication administration monitoring has not been documented or completed. A medication chart was obtained on the day of audit; therefore, the risk was reduced from moderate to low.	There was no medication chart or current pharmacy script in place for one resident. The resident was self-administering, but the self-administration process was not monitored by staff.	Ensure that all residents have a medication chart in place for self-administration of medicines and self-administration of medicine is monitored. 30 days
Criterion 1.3.3.3 Each stage of service provision	PA Low	Five files were reviewed. Overall initial assessments, care plans and care plan evaluations were completed within required time frames. The interRAI assessments and care plans updates were completed in timely manner in four files. In one file the interRAI assessment and the care	(i)Progress notes were not completed daily. (ii) In one file, interRAI assessment	(i)Ensure that progress notes are completed daily; and (ii)

<p>(assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>plan were overdue. The recreational therapist has completed activity assessments, resident's social history and activity care plans in timely manner.</p> <p>Notes by GP's and allied health professionals were evident in residents' files, as are significant events, communication with families and progress notes. More frequent GP reviews were evidenced as occurring in residents' files reviewed with acute conditions.</p> <p>Summerset requires daily input in to resident's progress notes. The service uses electronic patient management system, and review of progress notes showed gaps in daily recording. The gap was varied 2 to 3 days intervals. This was repeated four times in a month. Staff interviews confirmed that this was also identified as issue by the management and they are encouraged to report daily.</p>	<p>and care plan were overdue.</p>	<p>ensure care plan and interRAI assessments are completed at least six monthly.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.