

Melodie Enterprises Ltd - Sheaffs Resthome

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Melodie Enterprises Ltd
Premises audited:	Sheaffs Resthome
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 September 2020 End date: 2 September 2020
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:	25

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

Melodie Enterprises Limited took over the operations of Sheaffs Rest Home on 01 November 2019. There have been no significant changes to staffing, systems in use or the physical environment. The new owners have focused on ensuring safe and effective service delivery during their first year of operation. The service provides rest home level care for up to a maximum of 29 residents. Short stay /respite is also provided subject to bed availability. Day to day management of services is provided by the assistant manager who is supported by the owners who are both registered medical professionals.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with District Health Board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the owners, staff, and a general practitioner (GP). The GP, residents and families spoke positively about the care provided.

This audit identified two areas requiring improvement. These are related to the environment and maintenance of lifting equipment.

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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A complaints register is maintained with complaints resolved promptly and effectively.

Residents and families are provided with information about the Health and Disability Commissioners Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent. The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. There is no evidence of abuse, neglect or discrimination. The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

Residents and family members interviewed spoke positively about the comfortable, relaxed environment and the care and support provided.

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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An annual strategic plan describes the scope, direction, goals, values and mission statement of the organisation. The owners are involved in the running of the home and monitoring all aspects of service delivery. One of the owners is a general practitioner and the other is a registered nurse. Another part time registered nurse is employed to be on site four days a week. The owners are on site for various hours most days of the week.

The quality and risk management system collects quality data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. Policies were current and are reviewed and updated as needed at regular intervals.

The appointment, orientation and management of staff adheres to good employment practices. There is a systematic approach to identifying and delivering ongoing staff training. This supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents. Residents' information is kept safe, secure onsite and all entries are legible.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents are assessed by the Needs Assessment Service Co-ordination (NASC) prior to entry to the service to establish the level of care. The processes for assessment, planning, provision, evaluation, review and exit are provided by the registered nurses (RNs). InterRAI assessments and individualised care plans were sighted.

There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP). The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent.

Two experienced and enthusiastic diversional therapists offer a range of activities suitable for rest home level care residents each week day. The residents and family/whanau interviewed were very happy with the programme.

Nutritious meals, snacks and fluid are provided by a kitchen staff who have obtained qualifications in safe food handling. There is an approved food control plan. Residents who require special or modified meals are reliably catered for.

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.		Some standards applicable to this service partially attained and of low risk.
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Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry and cleaning are undertaken by care staff and evaluated for effectiveness.

The home is kept clean and fit for purpose. The furniture and chattels are in good condition and are regularly maintained. External areas are accessible and safe for residents' use. Communal and individual spaces are maintained at a comfortable temperature...

Staff are trained in emergency procedures, use of emergency equipment and supplies and they attend regular fire drills. Residents reported a timely staff response to call bells

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There was one resident using restraint and none on enablers at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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 infection control programme is developed in consultation with the relevant key stakeholders. The environment is managed in a way that minimises the risk of infection to residents, staff and visitors. The infection control coordinator (ICC) is responsible for monitoring infections, surveillance of data, trends and implementing relevant strategies. There was no infection outbreak reported since the last audit.

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	48	0	2	0	0	0
Criteria	0	99	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Sheaffs Rest Home has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and in ongoing training as verified in the training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files sampled showed that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) or residents and the general practitioner makes a clinically based decision on resuscitation authorisation if required. Some files sampled contained copies of any advance care planning and the resident's wishes for end of life care. Staff were observed to gain consent for day to day care. Interviews with residents and family confirmed the service actively involves them in decisions that affect them and their family members' lives.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents interviewed were aware of the advocacy service, how to access this and their right to have support persons. The RN/Owner and staff provided examples of the involvement of advocacy services in relation to residents' care.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends, however due to Covid-19 there are some restrictions in place for the safety of the residents, staff and members of the public. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms including the complaints register reviewed meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families during admission and those interviewed said they felt comfortable and wouldn't hesitate to raise a concern if they had one.</p> <p>There have been no formal complaints received under the new ownership. Residents are encouraged to raise concerns at their six weekly meetings. These concerns are documented and investigated where indicated. The diversional therapists notify any concerns raised and report back to the residents at subsequent meetings. The owners have made themselves known and are available to residents and relatives.</p> <p>All staff interviewed confirmed a good understanding of the complaint process and what actions are required. There have been no complaints to the Health and Disability Commissioner (HDC) or the DHB nor any requests for advocacy services to provide support for residents in this certification period.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family members and residents interviewed were aware of consumers' rights and confirmed that information was provided to them during the admission process.</p> <p>The information pack outlines the services provided. Resident agreements signed either by the resident or</p>

		by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board contractual requirements.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence and can move freely into the surrounding facility gardens and in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The registered nurse/owner (RN/Owner) reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. The GP reiterated that there was no evidence of any abuse or neglect reported. Family/whanau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. It also recognises the importance of whanau. The registered Nurse (RN) and diversional therapist (DT) who is a cultural advisor reported that assessments and care plans would document any cultural/spiritual needs, this was confirmed in the records sampled. Special consideration of cultural needs is provided in the event of death as outlined in the policy. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. There were four residents who identified as Maori at the time of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and</p>	FA	<p>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the residents and family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans sampled.</p>

beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and this was confirmed by the residents. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The RN/Owner stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice for example reviewing and updating them following any latest research updates. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures. Staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards is encouraged.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The quality/business/risk plan outlines the purpose, values, scope, and direction of the organisation. This is reviewed annually and contains annual and longer-term goals. A sample of staff meeting minutes for 2019-2020 confirmed regular discussions and actions to monitor organisational performance such as occupancy, human resources (HR), and quality and risk data including any emerging risks or issues. The two owners took over service delivery in November 2019. One of the owners used to be the facility GP and knew the residents and many of the organisational systems. The other owner is a practising registered nurse. Both owners hold tertiary health qualifications and are suitably skilled and experienced with delivery of service to older people. The assistant manager has experience in care giving for older people, people

		<p>management and quality and risk systems.</p> <p>The organisation holds contracts with the Bay of Plenty DHB, for rest home level care, and short stay respite care. There is also an agreement to provide activities to people living in the community but this is not being utilised. The home can accommodate 29 residents, but has not exceeded 28 residents for some time. On the days of this audit, there were 25 long term residents. All but one resident who is funded by ACC were under the aged residential care contract. There is a boarder living next door to the home who is provided a main meal but doesn't access any other services.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The two owners provide cover for the RN and deputy manager's role. This proved to be effective during the Level 4 Covid19 lockdown when the RN employed could not be on site. Both owners share on call responsibility every alternative week.</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>	FA	<p>The service has an established quality and risk management system which includes policies and procedures that guide best known practice. The policies used are a generic system moderated by an external quality consultant and these cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>Review of the business, quality and risk management plan revealed that goals are set and updated annually and signed off when completed. Compliance with these standards, the DHB contract and safe practice is monitored by internal audits and resident and family feedback. Approximately three audits are conducted each month. Where these identify areas for improvement, corrective action plans are documented and implemented. Results of audits and monthly analysis of complaints, incidents/accidents and infections are shared with staff at handover time and presented again at bi-monthly staff meetings. This was confirmed by staff interview and review of a sample of meeting minutes. There was sufficient evidence for example, documents, observations and interviews, to show that management and staff respond to things that require improvement by implementing corrective actions as soon as practicable. Other quality improvement matters including review of hazards and health and safety matters are discussed at staff meetings.</p>

		<p>All quality data such as incidents/accidents and infections are analysed and reported against regularly to identify trends.</p> <p>The residents and family interviewed said they experienced staff as easy to approach and felt encouraged to provide feedback to the owners or any staff member.</p> <p>Annual resident/family satisfaction surveys are conducted and the results from the 2020 survey indicated that residents and their families are happy with the services provided.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on hard copy accident/incident forms. The sample of forms reviewed from January to August 2020 were consistent in clearly describing and detailing the incident and recording who had been notified. All incidents are collated monthly and then presented for discussion at staff meetings. The records show on average five falls with no injury each month. The most frequent incidents are residents' behaviour and wandering due to two residents' cognitive decline.</p> <p>There are seldom any medicine errors (one pharmacy error to date in 2020) and three staff injuries reported. An annual report of statistics and quality which includes a summary of incidents and accidents, infections, hospital admissions, transfers, deaths, respite care provided, and staff training completed is well documented and demonstrates in depth review and trending. The RNs review all incidents/accidents and investigate where necessary. Each incident form reviewed contained comments on preventative action or for closure or follow-up.</p> <p>Families, the GP, progress notes and other documents reviewed, confirmed that family or significant other people are notified of events when they occur.</p> <p>The owners demonstrated understanding about essential notification reporting requirements, including for pressure injuries. It was advised there have been no events requiring notification to the Ministry of Health, or the DHB since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Staffing policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. Copies of current practising certificates are held on file. A sample of staff records reviewed, confirmed the organisation's policies are being consistently implemented and records are maintained. The deputy manager routinely reviews personnel records to ensure compliance with policy and employment legislation.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed</p>

		<p>orientation and a performance review after a three-month period and then annually. Performance appraisals are scheduled to occur in September.</p> <p>Continuing education is planned on an annual basis and occurs each month. These include mandatory training requirements such as fire drills, first aid, and medicines competency for those who administer medicines and other education to meet the requirements of the provider's agreement with the DHB.</p> <p>Of the nine carers employed, five have achieved level 3 of the National Certificate in Health and Wellness, one is at level 2 and one is at level one. The carers who have not completed a qualification in aged care are very experienced. There was sufficient evidence that all staff attend ongoing training</p> <p>The RN is maintaining competency to undertake interRAI assessments and the owner RN has also completed interRAI training.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week.</p> <p>Observations and review of a month's roster cycle confirmed that adequate staff cover has been provided, including for unplanned absence. The RN is employed to be on site four days a week from Saturday to Tuesday, the RN owner is on site each Wednesday and the GP owner visits each day after 2pm and is on site each Thursday. Friday clinical cover is shared between the two owners. All staff have a current first aid certificate. Staff work 10 hour shifts with staggered starting times so that there is extra support for residents when most needed.</p> <p>There is a total of 15 staff employed including the deputy manager; a registered nurse, two diversional therapists; caregivers and cooks. Staff complete laundry and cleaning and state that there are enough numbers of staff on duty at any time to ensure that residents can be cared for as per their individual needs. Staff are replaced when on leave as confirmed through a review of the rosters.</p> <p>The owners and care staff interviewed stated that staffing levels are adjusted to meet the changing needs of residents. The two owners share on call duties for after hour's clinical advice. Care staff reported there were adequate staff available to complete the work allocated to them. This was supported by the residents and family members interviewed.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is</p>	FA	<p>A resident register is maintained of all current and past residents. Resident individual information is kept in paper format. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated</p>

<p>uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>with GP and allied health service provider notes. Written records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on and off site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. Sheaffs Rest Home's welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe medication management system was observed. Indications for use are noted on 'as required' medications, allergies are clearly indicated, and photos are current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. All medicines are reviewed every three months and as required by the GP.</p> <p>A registered nurse was observed administering medications safely and correctly. The medication and associated documentation are in place. Outcomes of pro re nata (PRN) medication are documented. Medication reconciliation is conducted by the RNs when a resident is transferred back to service. The RNs checks medicines against the prescription. A total of six resident packs are checked on rotational basis every month. There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. There were no residents self-administering medications and there is self-administering policy in place if required. The controlled drug register is current and correct. Weekly and six-</p>

		<p>monthly stock takes were conducted, and this was confirmed on previous entries. Medication competencies for care staff and RNs who administer medicines were current.</p> <p>Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal are reported and attended to promptly. The service does not keep any vaccines.</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>	FA	<p>Food services are provided on site by two cooks who have completed safe food handling training. The menu adheres to recognised nutritional guidelines for older people and follows a four-week rotated menu pattern. The menus were reviewed by a registered dietitian two years ago (September 2018) with no recommendations. These are planned to be reviewed again before the end of this year.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with a food safety plan and registration was issued on 19 March 2020 and expires in September 2021. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Three residents are provided with soft meals and one with diabetic meals. Special equipment, such as modified plates and cutlery is available for those residents who need this to make eating easier.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Resident and family feedback about the quality and variety of food provided was very positive.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The RN/Owner reported that all consumers will be noted and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the resident will be admitted to the appropriate service provider.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Initial assessments were completed within the required time frame on admission while resident care plans and interRAI assessments were completed within three weeks according to policy. Assessments and care plans were detailed and included input from the family/whanau and other health team members as appropriate. Additional assessments were completed according to the need, for example, behavioural, nutritional, continence, skin and pressure assessments. The RNs utilise standardised risk assessment tools on admission. In interviews conducted, residents and family/whanau expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans and progress notes were completed for short-term needs. Family/whanau and residents interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, palliative and district nurses, dietitian and GP.</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>Interventions are adequate to address identified needs in the care plans. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. The GP reported that medical input was sought in a timely manner, that medical orders were followed, and care is person centred. Health care assistants confirmed that care was provided as outlined in the care plan. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Activities are planned by the two diversional therapists (DT) in consultation with other staff and the owners. The monthly activities plan is on display throughout the home and residents are reminded about the day's activities via a large blackboard and verbal prompting. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Each resident's capabilities and interests are taken into account, with input from family/whanau if appropriate during the assessment and planning process. There is a wide range of activities offered: including bingo; quiz; music sessions; gardening, walking groups; scrabble, knitting; colouring and housie. External entertainers, church groups and van outings were suspended during the Covid19 lock down periods. Outside of these times individual residents have been supported to do personal shopping. Each resident's attendance/engagement with activities is recorded daily. The residents' activities needs are evaluated by the DT's in consultation with the nursing team six-</p>

		<p>monthly</p> <p>The outcomes from residents' six weekly meetings are documented and communicated to staff, family/whanau and residents. A newsletter with information about the homes planned and completed activities is sent to family/whanau every six weeks. The DTs attend monthly meetings with other activities staff from rest homes and hospitals in the area. Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented daily by care staff in the progress notes. The registered nurses document weekly or as necessary. All noted changes by the health care assistants are reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change. These are carried out by the RNs in conjunction with family, GP and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP and RNs sends a referral to seek specialist service provider assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses, or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	FA	<p>Staff adhere to the documented processes for the safe management of waste and infectious and hazardous substances, as confirmed by onsite observations and interviews. Hazardous chemicals are stored securely, and staff described appropriate processes for protecting themselves and others from</p>

<p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>exposure to body waste. Soiled linen is separated. An external company is contracted to supply and manage all chemicals/cleaning products and provide training for staff on new chemicals. All staff have received education on safe chemical handling. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is more than adequate provision and availability of protective clothing and equipment on site. Staff and visitors were observed to be using face masks.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building warrant of fitness is current and due to expire in June 2021.</p> <p>Appropriate systems are in place to ensure that the residents' physical environment and facilities are fit for their purpose and maintained. Inspection of all areas revealed no unsafe areas. The testing and tagging of provider and resident owned electrical equipment for electrical safety is current. Calibration of bio medical equipment is schedule to occur in the next two months. This has been slightly delayed by national Covid19 lockdown in March to April. The environment is hazard free and resident's safety and independence is promoted. External areas are safe and pleasant for resident's use. There are adequately shaded areas and safe and suitable furniture is provided appropriate for rest home level care residents.</p> <p>Reactive and preventative maintenance is carried out by a range of local contractors. Residents and staff said they are happy with the environment and things are fixed or replaced in a timely manner.</p> <p>There was no evidence that the three hoists on site had been safety inspected since 2018. Staff said these were seldom used. Action is required to routinely check these are safe for purpose.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>PA Low</p>	<p>There were sufficient bathrooms and toilets throughout the home for the number of residents. One bedroom has a full ensuite bathroom, and eight other rooms have an adjoining shower and toilet between two rooms (for example, four showers and toilets) There are six other toilets and four shower rooms with functional locks and privacy signage for use by the other 16 residents. Staff have a separately allocated toilet.</p> <p>Hot water temperature monitoring to check the water is at a safe temperature, occurs monthly. The temperatures recorded are at below 45 degrees in bathrooms and 60 degrees in the kitchen and laundry.</p> <p>Improvements are required to the surfaces in one of the bathrooms.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p>	<p>FA</p>	<p>All bedrooms have single occupants. Residents who require mobility aids and/or staff assistance, occupy larger rooms. These inspected provide sufficient space for transfers and use of equipment.</p>

<p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The home has a spacious and welcoming open plan lounge and dining room which is the hub for daily activity and socialising. There are other inside and outside areas if someone doesn't want to participate in the programme or residents may choose to stay in their rooms. Furniture is appropriate to the setting and residents' needs. The majority of residents are independently mobile enabling them access to all areas including the outside via disability accessible ramps. One resident in a wheelchair can self-manoeuvre for short distances. Visitors tend to meet with their family and friends in communal areas or in their rooms for privacy.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Care staff provide the laundry and cleaning services. These tasks are carried out predominately in the morning. Staff interviewed about laundry demonstrated good knowledge of laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and that their clothes are returned in a timely manner, although one family member expressed concern about damage to their loved one's clothing. This was discussed with the owners during the audit. The machines and equipment provided are fit for purpose. Staff change each resident's bed linen once a week and stated there is sufficient time allocated for completing daily/weekly tasks. The care staff also carry out cleaning tasks such as rubbish removal, dusting, vacuuming and bathroom cleaning each day. An additional staff person had recently been contracted to complete deep cleans of each resident's bedroom. All staff have attended training in the safe handling of the chemicals on site and in health and safety matters, as confirmed by review of personnel files and interviews with staff. Bulk chemicals are stored in a lockable room when not in use and are decanted into clearly labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. All areas of the facility were clean on audit days. The residents and family members interviewed were happy with the cleanliness of their rooms and other areas in the home.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are current and are known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency.</p> <p>An updated fire evacuation plan was approved by the New Zealand Fire Service in 2010. Trial evacuations take place every six months. The most recent drills occurred in November 2019 and 29 June 2020. The</p>

<p>response during emergency and security situations.</p>		<p>time taken for evacuation is recorded and there have been no issues or risks identified. The most vulnerable or mobility impaired residents are listed on the fire board and are assisted first. The new staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a power outage or civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for maximum 28 residents. There are 15 litre boxes of potable drinking water in each resident's room, plus extra boxes in the garage and emergency lighting is regularly tested.</p> <p>The call bell system was functional on audit days and staff were observed to attend to these in a timely manner. Residents and families were happy with staff responses to call bells at all times of the day and night.</p> <p>Staff lock the external doors and windows each night for security purposes</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Each room and the corridors have natural light and opening external doors or windows. Heating is provided by heat pumps in communal areas and in residents' rooms. Areas were warm and well ventilated throughout the audit and residents and families confirmed the home is maintained at a comfortable temperature year-round.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Sheaffs Rest Home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The RN is the infection control coordinator (ICC) and is assisted by the RN/Owner. They have access to external specialist advice from the GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control and prevention programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control and prevention programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. There has been no infection outbreak since the last audit. The facility pandemic plan was reviewed, and adequate resources were sighted in relation to</p>

		personal protective equipment. The Covid-19 information board was updated. Residents are reminded daily on the latest updates on Covid-19 information. Extra staff will be provided in the event of an outbreak. Staff interviewed demonstrated an understanding of the infection prevention and control programme.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the monthly staff meetings. The ICC and RN/owner have access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	The organisation has documented policies and procedures in place that reflect current best practice. Policies and procedures are updated, staff informed and training conducted if required. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	Staff education on infection prevention and control is conducted by the ICC, GP/owner and other specialist consultants. The infection control coordinator attended infection prevention and control training conducted by the local district health board to keep their knowledge current. A record of attendance is maintained and was sighted. The training education information is detailed and meets best practice and guidelines. External contact resources included the GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their

		everyday practice.
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 infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service demonstrated the use of restraint is actively minimised. There was one resident using bed rails as restraint and none using an enabler during the audit. The restraint coordinator is the RN assisted by the general practitioner/owner (GP/Owner). Resident's own GP demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register was current and updated. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two. Restraint is an agenda item at the staff meetings. Meeting minutes and staff confirmed this.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The use of restraint is approved prior to commencing the restraint, this includes the resident's GP. Three-monthly reviews of restraints are completed. A signed job description for the restraint coordinator was evident in the restraint coordinator's file. Responsibilities of the restraint coordinator and approval process are clearly outlined. Restraint use is discussed during staff meetings. Staff confirmed their knowledge of the restraint processes.
Standard 2.2.2: Assessment Services shall ensure rigorous	FA	The file of a resident using a restraint was reviewed. Restraint assessment/consent forms were completed prior to commencing restraint. Family/whanau confirmed their involvement. The GP was involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying

assessment of consumers is undertaken, where indicated, in relation to use of restraint.		aetiology, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Care plan clearly documented any risk and desired outcomes. Staff demonstrated knowledge of maintaining culturally safe practice when completing assessments for restraint use.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Restraint minimisation policies and procedures are accessible for all staff to read. Safe use of restraint is actively promoted. There was a current and updated restraint/enabler register. Care plan included any risk factors and ensures the resident's safety while using restraint. Staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. There were no restraint-related injuries reported. Monitoring forms are in place for the resident who is using restraint and these were completed as required.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	In interview conducted the GP/owner and RN reported that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews six monthly and three monthly by the restraint coordinator and at the restraint approval group meetings. Family/whanau is involved in the evaluation process. The evaluation includes all requirements of the Standard including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and if documentation was fully completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The quality review of restraint is monitored through the internal audit programme. Identified issues are discussed at the staff meetings as well as additional education that is required to support staff. This includes education relating to restraint and challenging behaviour. Staff demonstrated sound knowledge relating to managing challenging behaviours.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	Three hoists (two sling and one standing hoist) are located within the home. Staff and the owners couldn't recall when these were last used to assist resident lifting. Maintenance procedures don't describe frequency of hoist inspections and the last recorded check attached to the hoists is dated 2018. Staff training on safe use of hoists occurred in 2019.	There was no evidence that the hoists are being regularly safety checked.	<p>Ensure all hoists are in safe working order</p> <p>180 days</p>
<p>Criterion 1.4.3.1</p> <p>There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This</p>	PA Low	The floor in one bathroom is degraded and there are heavy urine stains at the base of the toilet bowl. The MDF shelving of a wall cabinet in the same bathroom is also degraded.	The damages and deteriorated floor and wall cabinet surfaces in one bathroom inhibit	Ensure all surfaces in wet areas are intact.

excludes any toilets/showers/bathing facilities designated for service providers or visitor use.			cleaning and pose a risk of cross infection.	180 days
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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.