Experion Care NZ Limited - Greendale Residential Care

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 Q-Audit Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Experion Care NZ Limited
Premises audited:	Greendale Residential Care
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 October 2020 End date: 28 October 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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Greendale Residential Care is an aged care residential facility owned by Experion Care NZ Limited. The service provides rest home level care. On the day of the audit there were 25 residents.

There has been a change of clinical manager the last audit.

This surveillance audit was conducted against a subset of the Health and Disability Services Standards and the service contract of the district health board (DHB). The audit process included review of policies and procedures, review of residents and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

Of the three previous areas requiring improvement two areas relating to restraint have been addressed and maintained. The finding regarding neurological examinations being completed when a resident has an unwitnessed fall has been partially addressed.

There are four areas of partial achievement requiring corrective action plans identified during this audit. These relate to ensuring the timing of care plan development; interRAI assessments are complied with; assessments following unwitnessed falls and ensuring the medication room temperature is recorded.

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.

Residents and their family are provided with information on entry to the service. Open disclosure is practiced and there is ongoing communication with residents and family. There is access to interpreting services if required.

The implemented complaints process is known by staff, residents and resident families and aligns with requirements.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The organisations owner provides governance functions. The nurse manager and clinical manager have extensive experience in the aged care sector. Both are supported by other organisational managers and non-clinical staff.

There is a documented and implemented quality and risk management programme. Quality data is collected and analysed for trends. There are policies and procedures to support provision of appropriate support to residents.

A staff training schedule is in place. Rosters, staff, resident and family interview indicate sufficient and appropriately skilled staff are available in the service.

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.

The clinical manager (CM) and the nurse manager (NM) manage the new resident's admission process. The general practitioner (GP) is involved in the admission process and three-monthly reviews of medications or earlier as required. Residents' medical admission is completed in a timely manner. The nursing team is responsible for developing the care plans.

Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There are policies and procedures that document the service providers' responsibilities in relation to medication management. All medication administration competencies are current. The service uses a pre-packaged medication system that is paper based.

Food, fluid and nutritional needs of residents are provided in line with the recognised nutritional guidelines appropriate to the residents' needs.

Safe and appropriate environment

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

The buildings are suitable for the needs of residents with safe external areas. The building warrant of fitness is current and equipment regularly checked and calibrated.

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.

Policies and guidelines are in place regarding the use of restraints, enablers and management of challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated an understanding of restraint and enabler use and it was confirmed staff receive ongoing restraint education.

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.

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. Staff receive infection control education during orientation and annually thereafter. The nurse manager is the infection control coordinator and is responsible for monitoring infections, surveillance of data, trends and implementing relevant strategies. There have been no infection outbreaks reported since the last audit. The facility demonstrated that procedures were in place to manage the Covid 19 pandemic.

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	3	1	0	0
Criteria	0	38	0	3	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a detailed complaints process set out in policy and in alignment with Right 10 of the Code of Health and Disability Consumer Rights. The complaints process is detailed in the residents welcome pack. Complaints forms are available in the front foyer of the facility along with information on available advocacy services. The Code of Rights posters are also displayed in the foyer area. A complaints register is maintained for both verbal and written complaints. One complaint had been received since the last audit. Processes and timelines for response to this complaint met requirements. The clinical manager and nurse manager are responsible for all complaints and responding in writing. Complaint review is used to inform the quality process. Residents and family interviewed confirmed that they felt able to raise concerns with staff and that managers responded within an appropriate timeframe. There have been no complaints requiring statutory or DHB reporting since the last audit.
Standard 1.1.9: Communication Service providers	FA	Staff education has been provided related to appropriate communication methods. Residents' files and family interviewed confirmed residents and families are consulted and informed of any untoward event or change in care provision. Accident/incident forms sampled evidenced open disclosure. Policies and procedures are in place if interpreter or advocacy services are required. The general practitioner

communicate effectively with consumers and provide an environment conducive to effective communication.		interviewed reported satisfaction with communication from staff.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Greendale Residential Care is one of a group of rest homes owned by Experion Care NZ Ltd. The nurse manager has been with the organisation for four years and is responsible for the overall running of Greendale facility, plus one other Experion Care NZ Ltd service in Napier. There is a clinical manager (registered nurse) with extensive aged care experience, who oversees the day to day running of the home with support from the nurse manager. The organisational business plan included goals, mission, values and objectives defined in measurable terms. The quality plan is reviewed annually and includes quality goals, health and safety, risks and quality improvement plans. Greendale Residential Care is currently certified to provide 25 beds (aged related residential care (ARRC), respite and day care, long term support – chronic health conditions LTS-CHC) and mental health in aged residential care (MH in ARRC)). On the day of the audit there were 25 residents - 23 ARRC residents and 2 (MH in ARRC) residents (one under 65 years and one over 65 years). The additional ARRC resident related to a husband and wife sharing a double room. There were no individuals using respite or day care service at the time of the audit.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	There is a documented quality and risk management plan current to 2020, with annual review evidenced. The plan sets out quality goals and outlines action plans and progress towards achievement. Risks, responsibilities and controls are identified. Quality and risk are integrated into the business plan and other organisational systems including: incident/accident process; complaints system; infection control and the health and safety system. Managers and staff interviewed report quality and risk information is regularly shared at staff meetings, confirmed on review of staff meeting minutes. The nurse manager completes a comprehensive monthly report which is sent to the owner of the organisation. The quality programme includes monitoring the implementation of policies and procedures; incidents/accidents; complaints; infection control; internal audits; environmental monitoring and health and safety. Data is collected, collated and analysed, with results discussed at staff meetings. Improvement opportunities are noted and monitored for effectiveness. A hazard identification and mitigation process is implemented. The hazard register is regularly reviewed by the nurse manager and updated as required. Key components of service delivery are linked to the quality system and are standing agenda items at monthly staff meetings. These include infection prevention and control; health and safety; adverse events and education. Staff are provided with a copy of the monthly quality report. Interview with staff, family and

		residents confirmed they are comfortable raising any issues with management and that issues are addressed. A schedule of internal audits is implemented, and 2020 results sighted. The information from internal audits is reported in the monthly quality report. Service shortfalls are identified and monitored until the required threshold is met. Corrective actions are developed to address issues and a process for close off is in place. Not all corrective actions sampled were closed off. Improvement opportunities are noted and monitored for effectiveness. Policies and procedures are relevant to the facility and available to staff. There is a document control policy that is integrated into the policy system. All staff undergo health and safety training, and this is a designated health and safety representative.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	There is a system for reporting and managing adverse events. Staff record adverse, unplanned or untoward events on an incident/accident form. The nurse manager collates and records incidents and reports on these at monthly staff meetings and to the service owner. Management are aware of the statutory requirements for reporting. Staff interviewed confirmed their understanding of the process and the need to report. Residents and family interviewed confirmed awareness of the adverse event reporting process. Ten incidents/accidents were reviewed and reflected that forms are completed, and families and the residents' general practitioner are informed as appropriate. Incidents sampled included unwitnessed resident falls. Not all corrective actions relating to adverse events were closed off (link to 1.2.3.8). Documentation has been updated to include the requirement for neurological assessments to be completed for all unwitnessed falls and review by the GP undertaken if required. Two of five incidents forms related to unwitnessed falls did not evidence completion of neurological assessment as per requirements. This component of the previous finding has not been addressed and remains open.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet	FA	Human resource policies and procedures are in place and support good practice. There is a defined recruitment process. The nurse manager and clinical manager are responsible for undertaking recruitment processes. Five of five staff files sampled contained relevant employment documentation. Registered nurse and general practitioner annual practicing certificates sighted were current. Staff files reviewed and staff interviews evidenced all staff complete a comprehensive service orientation. The service training programme includes a range of mandatory staff education requirements. Non-clinical staff are also required to complete the New Zealand Certificate in Health and Wellbeing within 12 months

the requirements of legislation.		of commencing employment. The clinical manager has completed interRAI training. Staff performance is monitored. This includes annual performance appraisal. The residents, families and the general practitioner all reported satisfaction with the knowledge and skills of staff.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a staffing rationale policy. Rosters evidence that sufficient cover is provided on all duties. There is a registered nurse (the clinical manager) on morning shifts Monday to Friday and an additional registered nurse works two days per week. The nurse manager and clinical manager are on call 24 hours. A nurse manager from another of the organisations Napier based homes provides management cover when needed. Rosters sampled show there are two care workers on duty on the morning shift and afternoon shifts. There is one care worker on night shift; and the nurse manager and clinical manager are on call during the night shift. All sick and annual leave is covered using existing staff. There are sufficient numbers of kitchen, housekeeping and activities staff. Observations during the audit confirmed residents' needs were meet in a responsive manner. Family and general practitioner interviewed confirmed staff were available to meet resident needs as required.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements. Medication reconciliation of monthly blister packs is completed by a RN and any errors fed back to pharmacy. Registered nurses, and senior HCAs who administer medications have been assessed for competency on an annual basis. Registered nurses have syringe driver competency. Education around safe medication administration has been provided. Care staff interviewed described their role regarding medicine administration. Ten medication charts were reviewed on the electronic medication system. Administration charts demonstrate that medication is being administered as prescribed. All medication charts had been reviewed at least three monthly. Medication charts met the legislative requirements for the prescribing of regular medications. All prescriptions for 'as required' medications document the indication for use. Medications were stored safely in a medication room. Medication fridges were monitored weekly. The medication room temperature was not recorded as required. There were no self-medicating residents on the day of audit. The facility had systems and processes in place for self-administration should this be required.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a four weekly rotating seasonal menu that has been reviewed by a dietitian. Meals are prepared on site and served in the dining room; or taken to the resident's room if the resident is unable to attend the dining room. Staff were available to provide assistance as required in the dining room during mealtime. Dietary requirements, likes, dislikes and allergies of all residents are recorded on admission and adjusted thereafter as necessary, these details are available in the kitchen. The cook was aware of the residents' dietary requirements and updated with any changes. Dietary requirements are accommodated in the daily food plan and alternatives provided to residents when required. There is a system in place for managing food requirements, modified nutritional requirements and special diets. Staff in the kitchen and dining area were observed wearing hair protection. The kitchen and pantry are clean, tidy and well stocked. Food procurement is managed by the cook. Labels and expiry dates are on all containers and decanted foods, and expired foods are discarded. Food temperatures, fridge and freezer temperatures are recorded. There was a current food control plan in place. The kitchen staff have current food handling certificates. Resident's files demonstrated monthly monitoring of weight and supplements are offered to residents when necessary. Residents and family/ whanau interviewed expressed satisfaction with meals. The chef confirmed that satisfaction for the food service is one to one and wastage is monitored to determine likes and dislikes.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	A written record of each resident's progress is documented. Resident changes in condition are followed-up by a registered nurse as evidenced in residents' progress notes. The care plans reviewed documented interventions that reflected the resident's current needs. When a resident's condition changes, the RN initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. The one family member interviewed stated they have been notified of changes to their relative's health. There was documented evidence of relative contact for any changes to resident health status. Monitoring charts sighted had been fully documented. Personal protective equipment and continence products are available. Care workers and RNs interviewed stated there are adequate personal protective equipment, continence and wound care supplies. Wound assessment, monitoring, wound management plans and short-term care plans are in place as required. On the day of the audit there was one wound, a small ulcer to a skin tear. The RNs have access to specialist nursing wound care management advice through the district health board (DHB) as required.

Standard 1.3.7: Planned Activities 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.	FA	Activities are planned by the activities officer in consultation with the CM and NM. A monthly planner is distributed to all residents and posted on the notice boards that are accessible to residents. A resident preference/choice of activities form is completed on admission. The activities provided take into consideration residents' interests and ability. Residents and their family/whanau are consulted in the activity's assessment and planning process. There is a wide range of activities offered: including bingo; word building; and music sessions. Van trips occur twice a week and are popular, destinations have included the beach, RSA and church. Community involvement includes external entertainers. Daily activities attendance checklist is completed, and evaluation of individual activity plans is completed six monthly. Activities include group and one to one and cater for those under and over 65 years of age. Monthly residents' meetings are conducted, and outcomes are implemented and communicated to family/whanau and residents. Interviewed residents and family member reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate initial care plans within three weeks of admission and long-term care plans are evaluated at least six monthly or earlier if there is a change in health status and six-monthly reassessments have been completed by RNs using interRAI. (With the exception of link 1.3.3.3.) There is at least a three-monthly review by the GP. All changes in health status are documented and followed up. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness was displayed. The building was observed to be appropriate and suitable to the needs of the residents with safe external areas. Residents interviewed reported all aspects of the facility are comfortable and suitable for their needs.
Standard 3.5: Surveillance Surveillance for infection is	FA	The facility has a policy in place for infection prevention and control which was updated with policies for Covid 19. The facility is currently monitoring all residents using daily symptom checkers; temperatures and

carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		oxygen saturations are recorded. Increased education has been provided to staff in response to the Covid 19 pandemic. This has included the use of PPE, donning and doffing and social distancing. The infection control coordinator monitors all infections, causative organisms, and antibiotic use. The trends and findings are made available in the staff meeting minutes, staff handovers and the risk management monthly report. An infection control walk around, and handwashing audit occurs monthly. Staff confirmed there has been no outbreak within the facility within the last year.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a documented restraint policy and procedure. De-escalation and behaviour management is actively practiced. There were no restraints or enablers in use on day of audit. There have been no incidents of restraint since the last audit. The NM stated that the use of sensor mats has reduced the need for restraints. The NM is the restraint coordinator and actively promotes a restraint free environment. There was evidence in staff interviews and training records that restraint minimisation and safe practice (RMSP), voluntary enabler usage and prevention and/or de-escalation education and training has been provided.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	There have been no incidents of restraint use since the last audit. The previous finding has been closed out.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	There have been no incidents of restraint use since the last audit. The previous finding has been closed out.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Data is collected, collated and analysed, with results discussed at staff meetings. Corrective actions are developed to address issues and a process for close off is in place, however this is not always completed.	Not all corrective actions sampled were closed off.	Ensure all corrective actions identified are closed off. 60 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Ten incidents/accidents were reviewed and reflected that forms are completed, and families and the residents' general practitioner are informed as appropriate.	Neurological observations are not routinely completed for all unwitnessed resident falls.	Ensure all staff routinely complete neurological assessments for all unwitnessed

		Incident forms have been amended to include the requirement for neurological assessments to be completed and documented for all unwitnessed resident falls, however this is not always occurring.		resident falls. 30 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Medications were stored securely in the medication room.	There was no documentation in place to demonstrate that the medication room temperature had been recorded as required. There was a document in place to record the temperatures, but there were no entries on the document.	Ensure the medication room temperature is recorded as required. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Two registered nurses are interRAI trained and complete the interRAI assessments.	(i) InterRAI assessments were completed within 21 days of admission with the exception of one file reviewed. The interRAI for this resident was more than three months late. (ii) Long-term care plans were completed within three weeks of admission by registered nurses with the exception of one resident whose file was reviewed, and the long-term care plan was completed five weeks following admission. (iii) The interRAI report generated from the interRAI website demonstrated that reviews were not completed within the required time frames for nine residents.	(i) Ensure all initial interRAI assessments are completed within the required time frames. (ii) Ensure all initial long-term care plans are completed within the required time frames. (iii) Ensure all interRAI

				reviews are completed within the required time frames. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.