The Ultimate Care Group Limited - Ultimate Care Rosedale

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

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

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

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Rosedale
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 December 2020 End date: 4 December 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: 49

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

Ultimate Care Rosedale provides rest home and hospital level care for up to 66 residents. There were 49 residents at the facility on the first day of the audit.

This certification audit was conducted against the relevant Health and Disability Services Standards and the service contracts with the district health board.

The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with residents, family, management, staff, a nurse practitioner and a general practitioner.

Areas identified as requiring improvement relate to: human resources; medication management; facility specifications and restraint management.

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 about the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights is accessible to residents and family. Services are provided that support personal independence, individuality and dignity.

Policies and procedures are in place should a resident identify as Māori, to ensure their needs will be met in a manner that respects their cultural values and beliefs.

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

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

Open communication between staff, residents and family is promoted, and documentation confirmed this to be effective. There is access to interpreting services if required. Staff provide residents and family with the information they need to make informed choices and give consent.

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

Organisational management

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

The Ultimate Care Group Limited is the governing body responsible for the services at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned. There are systems in place for monitoring the services provided, including regular monthly reporting by the facility manager to the Ultimate Care Group national support office.

The facility is managed by an appropriately qualified and experienced facility manager who is supported by a clinical services manager. Ultimate Care Group's national executive and regional teams support the service.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented and investigated. Indicators, quality and risk issues, and identified trends are discussed at staff meetings. Graphs of clinical indicators are available for staff to view along with meeting minutes.

Human resource policies and procedures are documented and reflect good practice. The orientation programme is undertaken by newly recruited staff and is appropriate to their role. Practising certificates for staff and contractors are validated annually for those that require them.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice.

Residents' information is recorded, and securely stored in a manner that it is only accessible to authorised people.

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 medium or high risk and/or unattained and of low risk.

Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after admission.

InterRAI assessments are used to identify residents' needs. These are completed within the required timeframes. The general practitioner or nurse practitioner completes a medical assessment on admission and reviews occur thereafter on a regular basis.

Long-term care plans are developed and implemented within the required timeframes. Residents' files reviewed demonstrated that evaluations were completed at least six-monthly. Residents and their relatives are involved in the care planning process. Handovers between shifts guide continuity of care and teamwork is encouraged.

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

An electronic medication management system is in place. Medications are administered by registered nurses and senior health care assistants who have completed current medication competency requirements.

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

Safe and appropriate environment

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

There is a current building warrant of fitness. Electrical equipment is tested as required. There is a preventative and reactive maintenance programme. The facility meets the needs of residents and is clean and fit for purpose.

Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, and provide shade and seating. Residents bedrooms are of an appropriate size for the safe use of mobility aids and care provision. The lounge and dining areas are clean and maintained.

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

Waste is managed according to documented processes. Staff use protective equipment and clothing when required. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken on-site and evaluated for effectiveness. Cleaning of the facility is conducted and monitored by household staff.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse.

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 appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Ultimate Care Group national support office. There have been no outbreaks since the previous 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	46	0	2	2	0	0
Criteria	0	97	0	2	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Ultimate Care Rosedale (Rosedale) has developed policies, procedures and processes to meet its obligations 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 (refer to 2.1.1.4). Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's consent form. Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's records. Staff were observed to gain consent for day to day care.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the NHDAS. Posters and brochures related to the NHDAS were displayed and available in the facility. Residents' are provided with information on the advocacy service as part of the admission process. Residents and family interviewed confirmed their awareness of the service and how to access this.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their independence and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips and activities. Entertainment is provided by the facility with special theme weeks planned as witnessed during the audit. The facility has unrestricted visiting hours that support visits from residents' family and friends. Family interviewed stated they felt welcome when they visit and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The FM is responsible for the complaints' management. The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and family on admission. Interviews with residents, family and EPOAs confirmed that they know how to make a complaint and that they are guided by the written information provided in the facility. The complaints forms are displayed and accessible within the facility. Staff interviewed confirmed their awareness of the complaints process. The complaints register reviewed showed that two written complaints and ten verbal complaints have been received over the past year and that actions taken are documented and completed within the required timeframes. Action plans showed that required follow up and improvements have been made where possible. The roving facility manager (RFM) and the regional operations manager advised that there was one open complaint with the Health and Disability Commissioner (HDC). Documentation reviewed confirmed required timeframes have been met. An internal investigation has been completed with internal recommendations instigated. There have been no complaints from any other external agencies.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (NHDAS) as part of the information provided on admission, and through discussion with staff. Residents and family interviewed stated they would feel comfortable raising issues with staff and management. The Code is displayed throughout the facility with information on advocacy services. An advocate from the NHDAS visits the facility twice a week and attends the residents' monthly meeting.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff communicated their knowledge about the need to maintain residents' privacy and were observed doing so throughout the audit. Residents and family interviews confirmed that residents are encouraged to maintain their independence by participating in community activities and outings. Residents' care plans include documentation relating to residents' abilities and strategies to maximise independence. Residents' records sampled confirmed that residents' individual cultural, religious, social needs, values, and beliefs were identified, documented, and incorporated into their care plan. The policy on abuse and neglect was understood by staff interviewed, including what to do should there be any signs. Education on abuse and neglect is part of the staff orientation programme and mandatory staff education. The residents and the family interviewed confirmed they receive services in a manner that has regard for their dignity, privacy, spirituality, and choices.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There is a current Māori health plan that guides staff if a resident identifies as Māori. Any additional cultural support, if required would be accessed locally. This was confirmed during an interview with staff. There were no residents who identified as Māori at the time of audit.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture,	FA	The individual preferences, values and beliefs of residents are documented in the care plans reviewed. Residents and the family stated they had been consulted about residents' individual

Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		ethnic, cultural, spiritual values and beliefs, and confirmed that these were respected.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the organisation's 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. Staff confirmed at interview that they attended education sessions on the code of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, wound care specialist and the contracted nurse practitioner (NP). The general practitioner (GP) and NP 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	Residents' records reviewed confirmed that residents and family were kept informed about any changes to the resident status. Residents and family stated that they were advised in a timely manner about any urgent medical review or unexpected care situation. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Resident and family interviewed reported that they are informed of resident's meetings by email and that they receive the facility newsletter. Review of meeting minutes evidenced that there is an opportunity to provide feedback on services. Interviews with residents and family evidenced that the facility manager (FM) has an open-door policy and is approachable to answer any concern or question that arises. Residents' needs for interpreting services are discussed at the time of entry to services. Access to interpreters is organised through family, community groups or the district health board (DHB).

		Specific care arrangements made for residents with communication impairments were observed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ultimate Care Group (UCG) strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The organisation's values were visible on display in the reception area of the facility. The FM was on leave at the time of the audit and replaced by a RFM. The regional operations manager and the national clinical lead were present at audit and provided ongoing support to the Rosedale management team. The FM has been in the role since February 2020, and prior to this appointment was employed as the facility administrator then the assistant manager. The FM responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM is supported by the clinical services manager (CSM) who has been in the role for two weeks. The CSM has a current practising certificate and has worked at Rosedale for the past five years as a registered nurse (RN). The RFM, regional operations manager and national clinical lead confirmed knowledge of the sector, through membership of relevant associations. The RFM is a RN, with a current practising certificate and has previously held a FM position both in New Zealand and Australia. Rosedale has a total of 115 beds in their building, comprised of 34 hospital beds and 81 serviced apartments. The facility is currently certified for 66 beds that include 32 dual purpose beds and 34 hospital beds. The hospital wing can accommodate up to 34 residents and is split between two floors, 21 beds on the upper floor and 13 beds on the main floor. The dual-purpose beds are distributed across serviced apartments with occupational rights agreements (ORA) on the upper and main floors. At the time of the audit there were a total of 49 residents in the facility, 39 receiving hospital level care and 10 receiving rest home level care. Of the 39 residents receiving hospital level care, there were 33 in the hospital wing and 7 with ORA in the serviced apartments. There was one resident assessed at rest home level of care in the hospital wing and the remaining nine rest home residents resided in the serviced apartments with ORA. The facility holds an aged related residential care (ARRC) contract with the DHB for the provision of rest home, respite and hospital level of care. There were no residents receiving care under respite or under 65 years of age at the time of

		audit.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	When the FM is absent for a period greater than three days, a UCG RFM is appointed and carries out all the required duties under delegated authority. During absences of clinical staff, the clinical management is overseen by another RN in the facility, who is able to take responsibility for any clinical issues that may arise. Managers reported at interview the current arrangement works well.
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.	FA	Rosedale utilises UCG quality and risk management systems that reflect the principles of continuous quality improvement. Polices reviewed cover the necessary aspects of the service and contractual requirements, including reference to the interRAI long term care facility assessment and process. Policies include references to current best practice and legislation requirements. New and revised policies are presented to staff at staff meetings (sighted minutes) and policy updates are also provided as part of relevant in-service education. Staff interviewed confirmed that they are provided with copies of new and revised policies and opportunities to read and understand the policy content. Service delivery is monitored through the real time reporting system, which includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, such as clinical incidents including infections, falls, medication errors, sentinel events, weight loss and wounds. The regular patient survey results sighted indicated residents and family were happy with the services received. The internal audit programme is documented and implemented as scheduled. Internal audits cover all aspects of the service and are completed in a timely manner. Audit data is collected, collated and analysed. Where improvements are required following internal audits, corrective actions are developed. Interviewed staff reported that they are kept informed of audit activities and results at staff meetings. Facility meetings are conducted monthly. Minutes of meetings evidenced communication with staff around aspects of quality improvement and risk management. A review of the quality management data evidenced corrective actions plans were completed using the organisation’s electronic template. Documentation included the person responsible for implementation and the timeframe adhered to ensure the plan was completed and evaluated as to the effectiveness of the plan.

		Rosedale utilities the UCG risk management programme. Health and safety policies and procedures are documented along with hazard management programme. There was evidence of hazard identification forms completed when a hazard was identified and that hazards are addressed and risks minimised. Rosedale has appointed a new health and safety officer two weeks ago, when the previous health and safety person resigned. Health and safety training for the new health and safety officer is planned to commence in one week with the RFM giving oversight until training has been completed. A current hazard register was sighted on-site. Staff interviewed confirmed awareness of the process to report hazards.
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.	FA	Essential notification of reported events is the responsibility of the FM. The RFM interviewed when to report and notify statutory authorities including but not restricted to: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; disease outbreaks; and changes in key managers. Staff interviewed understood the adverse event reporting process in relation to their professional practice and regulatory requirements. They were also able to describe the importance of reporting near misses. Staff who witness an event or are first to respond to an event, document the adverse, unplanned or untoward accident/incident in a hard copy form which is transcribed onto an electronic management system. The system documents completion of tasks such as contacting the GP or the family. Reported accidents/incidents are monitored by the national support management team. The CSM is responsible for reviewing the lodged clinical accident/incident. Results from accidents/incidents are discussed at quality meetings. Family interviewed confirmed that they were notified where the resident had an accident or a change in health status. There have been three notifications to the ministry under section 31 since the previous audit, relating to both the facility and clinical services manager appointments, and one pressure injury.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Written policies and procedures in relation to human resource management are available. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice. The selection and approval of new staff is the responsibility of the FM and CSM. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities, and authority. These were reviewed on staff files along with employment agreements, reference checks and police vetting. Staff files reviewed showed performance reviews have not been consistently completed.

		Interviews with care givers confirmed new care givers are paired with a senior care giver for shifts or until they demonstrate competency of tasks including personal cares for residents. Competency assessments questionnaires for relevant competencies required for specific positions such as: orientation; hoists; handwashing; wound management; medication management; moving and handling were sighted in staff education files reviewed. There were five RNs including the CSM who were interRAI competent. The organisation has a mandatory education and training programme.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Ultimate Care Group has a national documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, 7 days a week (24/7). The facility has three separate rosters, one for each floor that operates hospital beds and one for the serviced apartment residents. The national team oversees the roster with the CSM adjusting the staffing levels locally to meet the changing needs of the residents. A RN is rostered on 24/7 to cover both the hospital and serviced apartments. The RN has a current first aid certificate. The ORA units are located within the facility close to the nurse's stations. The residents who are receiving rest home and hospital level care in ORA units have their needs met within the environment in which they live with 24 hour care, and sufficient staffing and availability of RNs to meet their needs with the ARRC agreement. Care giver staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. The facility utilises one specific staffing agency if additional RN or care giving staff is required. The FM, CSM and/or a RN are on call after hours and weekends seven days a week to support the facility with emergency matters.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when	FA	Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals. Records were legible with the name and designation of the person making the entry identifiable. Residents files reviewed included relevant information on the residents' care and supported information that could be accessed in a timely manner. There are policies and procedures in place to ensure privacy and confidentiality of resident's

required.		information. Staff interviews described the procedures for maintaining confidentiality of residents' records. No personal or private resident information was on public display during the audit. Electronic data is password protected and can only be accessed by designated staff. Residents files are held for the required period before being destroyed.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Needs Assessment and Service Coordination (NASC) assessments are completed for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. There is a comprehensive information pack provided to all residents and their family prior to admission. Prospective residents and/or their family are encouraged where possible to visit the facility prior to admission. Review of residents' files confirmed that residents who entered the service met the required criteria. Interviews with residents and family, and review of records confirmed the admission process was completed in a timely manner. Residents and family interviewed stated that they had received sufficient information prior to and on entry to the service.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Transition, exit, discharge, or transfer is managed in a planned and coordinated manner. Interviews with RNs and review of residents' files confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers. A transfer form accompanies residents when a patient is moved to another service or facility. Follow-up occurs to check that the resident is settled.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	A current medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. An electronic system for medicine management was observed on the day of audit. Prescribing practices in line with legislation were observed. The required three-monthly medication reviews by the GP/NP were recorded electronically. However, resident allergies and sensitivities were not consistently documented on the electronic medication chart. The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing

		orders used at the facility. Review of medications stored in the medication fridges evidenced that the service does not store or hold vaccines and interviews with the RN confirmed this. The medication refrigerator temperatures are monitored daily. However, there is no system in place to record the temperature of the medication rooms to ensure safe storage of medication. There is sufficient storage facilities for medications, two areas are used. The upstairs hospital has a medication room. Medications for the downstairs hospital and for the hospital and rest home level residents living in the ORAs are stored in the downstairs nurses' office. Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks and six-monthly stocktakes of medications are conducted in line with policy and legislation. The RNs oversee the use of all pro re nata (PRN) medicines and documentation regarding their effectiveness was sighted on the electronic medication record and in the progress notes. There were no residents self-administering medication during the on-site audit.
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	All meals are prepared on site. The seasonal menu has been reviewed by a dietitian. The food control plan's expiry date is July 2021. All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and a cool store. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated. Food temperatures are monitored appropriately and recorded daily. The kitchen was observed to be clean and cleaning schedules were sighted. All kitchen staff have relevant food hygiene and infection control training. A nutritional assessment is undertaken for each resident on admission by an RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident's dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs, likes and dislikes of the residents. These are accommodated in

		daily meal planning. Residents were observed to be given enough time to eat their meal and assistance was provided when necessary. There was enough staff to ensure assistance was available. Residents and family interviewed stated that they were satisfied with the meals provided.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service has a process in place if access is declined. At interview the CSM stated that when residents are declined access to the service, residents and their family/whānau, the referring agency and the GP are informed. The resident would be declined entry if not within the scope of the service or if a bed was not available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial nursing assessment and the initial care plan are completed within 24 hours of admission. The initial care plan guides care for the first three weeks. Registered nurses complete the interRAI assessment within the required timeframes. The long-term care plan is based on the interRAI assessment outcomes. Assessments are recorded, reflecting data from a range of sources, including: the resident; family/whānau; the GP and specialists. Policies and protocols are in place to ensure continuity of service delivery. Interviews with residents and family confirmed their involvement in the assessments, care planning, review, treatment, and evaluation of care.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Long-term care plans are developed with the resident and family/whānau involvement. All residents' files sampled had an individualised long-term care plan. Long-term care plans describe interventions to meet residents' assessed needs. Short-term care plans are developed for the management of acute problems. Resident files showed service integration with clinical records, activities notes, and medical and allied health professionals' reports and letters.
Standard 1.3.6: Service Delivery/Interventions	FA	Long-term care plans are completed by the RN and based on the assessed needs, desired outcomes and goals of residents. Interventions are reviewed within required timeframes. The GP/NP documentation and records reviewed were current. Interviews with residents and family

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		confirmed that care and treatment met residents' needs. Family communication is recorded on the family/whānau communication record. The NP interviewed visits the facility twice a week. They verified that medical input is sought in a timely manner, medical orders are followed, and stated that care is of a high standard. Monthly observations such as weight and blood pressure were completed and are up to date. Wound assessments, treatment and evaluations were in place for all wounds which included four stage two pressure injuries. In the residents' files reviewed, all residents had a pressure injury risk assessment in place, and interventions were documented for those residents identified as at risk of developing pressure injuries. There was evidence of referral to the DHB wound CNS and pressure relieving equipment was available. Scheduled change of dressings and evaluations had been completed. Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe access to the DHB wound CNS as required. Continence products are available and resident files documented continence assessments, and management.
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	The residents' activities programme is implemented by a diversional therapist in the village and an activities coordinator in the hospital. Activities for residents are provided six days a week, Monday to Saturday. Hospital and rest home level residents who live in the ORAs participate in the activities provided in the village. The activities programme was displayed on the resident noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural, spiritual and community events. Regular van outings into the community are arranged. Regular church services are held and a chaplain visits two or three times each week. The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on residents' interests, family and previous occupations is gathered and documented during the interview with the resident and their family. The residents' activity needs are reviewed six-monthly as part of the formal six-monthly multidisciplinary review process. The residents and their family reported satisfaction with the activities provided. Over the course of the audit, residents were observed engaging and enjoying a variety of activities.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN. Long-term care plans are evaluated every six months in conjunction with the interRAI re-assessments or if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Residents and family interviewed confirmed involvement in the evaluation process and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Where needed, referrals are sent to ensure other health services, including specialist care is provided for the resident. Referral forms and documentation are maintained on resident files. Referrals are regularly followed up. Communication records reviewed in the residents' files, confirmed family/whānau are kept informed of the referral process.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff (refer to 1.4.2.1). Safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should if any chemical spill/event occurred. There is provision and availability of protective clothing and equipment and staff were observed using this when required.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	There have not been any structural alterations to the building since the last audit. A current building warrant of fitness is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Residents are safe,

		and independence is promoted by ensuring the environment is free of hazards such as linen and cleaning trolleys are placed strategically to ensure residents are safe. All levels have a nurses' station that allows visibility to residents' rooms. A clean utility room is available for safe storage of medicines, supplies and residents' files. A new staff toilet has been installed on the ground level of the hospital wing. Additional equipment has been purchased including additional hoists and commodes in the hospital wing. External areas are safely maintained and are appropriate to the resident groups and setting. Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. Improvement is required relating to the chemical dispensers and serviced apartment refrigerators.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the building. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Hot water temperatures are monitored monthly. When hot water temperatures are above the recommended safe temperature, action is taken, and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around their bedrooms. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheelchairs, and mobility scooters. Staff and residents reported the adequacy of bedrooms for their needs.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe,	FA	Communal areas are available for residents to engage in activities. Dining and lounge areas on each level enable access for residents and staff. Residents can access areas for privacy, if required. Residents interviews confirmed there are alternative areas available to them if communal activities are taking place in the lounges and the dining room, in which they do not

adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		wish to participate. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site and on request in a dedicated laundry area. Dedicated laundry staff demonstrated knowledge of the laundry process, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their washed clothes are returned in a timely manner. There is a small, designated cleaning team who has received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. A sluice room is available on each level for the disposal of soiled water/waste. Cleaning and laundry processes are monitored through the internal audit programme and resident meetings.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to follow in the event of a fire or other emergency. There is a current fire evacuation plan, relevant to the current configuration, that has been approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service as sighted. The orientation programme includes fire and security training. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas barbeques were sighted and meet the requirements for the up to 66 residents. Water storage tanks are located around the complex. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and family reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises twice each night.
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	All residents' rooms and communal areas are heated and ventilated. Rooms have natural light and opening external windows. Heating is provided by heat pumps and wall heaters. All areas of the facility were observed to be warm and ventilated during audit, and residents and family

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Rosedale provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. The CSM is the infection control nurse (ICN) and has access to external specialist advice from the DHB, and microbiologists when required. A documented role description for the ICN, including role and responsibilities, is in place. The infection prevention and control programme is reviewed annually. Staff are made aware of new infections through daily handovers on each shift, progress notes and clinical records. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICN is responsible for implementing the infection control programme. The ICN has completed training for the role through Ministry of Health online training course and through the DHB. The ICN liaises with the DHB infection control nurse for education and expert advice. An infection control committee which is made up of staff members from each facility work area meets three-monthly. The ICN stated that there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's quality, clinical and staff meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention and control programme.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical,	FA	Ultimate Care Group has documented policies and procedures in place that reflect current best practice relating to infection prevention and control. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.

safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	All staff attend infection prevention and control training. Staff education on infection prevention and control is provided by the ICN at orientation and monthly at the quality meetings. Health care assistants and RNs receive further training at study days and from external infection control specialists. Records of attendance are maintained. Staff interviewed confirmed that education on infection prevention and control is provided by the ICN at orientation and monthly at quality meetings. Education with residents, when possible, is generally on a one-to-one basis and includes advice about handwashing, to remain in their room if they are unwell, and to increase fluids during hot weather. There is information regarding infection prevention and COVID-19 displayed on the noticeboards. Staff receive notifications and updates about infection control via noticeboards, meetings and at handovers.
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	Ultimate Care Group surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed. Short-term care plans are developed to guide care and evaluate treatment for all residents who have an infection. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. Family are updated by phone, email or text if required. Surveillance data is collected in the clinical areas and collated monthly by the clinical services manager and forwarded to the UCG national office for benchmarking. The ICN confirmed that there have been no outbreaks since the previous audit. Oceania information including Ministry of Health information was available on site. There are adequate infection prevention and control resources available should a resident infection or outbreak occur. There is an antimicrobial use policy.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	PA Moderate	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the CSM and they provide support and oversight for enabler and restraint management in the facility. The coordinator is conversant with restraint policies and procedures.

		On the day of the audit, there were two residents using approved restraints (bedrails) and one resident using an enabler (bedrails) that was used voluntarily at their request. A similar process is followed for the use of enablers as it is used for any restraint use. Restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of restraint minimisation. Regular training occurs, and review of restraint and enabler use is completed and discussed at all quality and clinical meetings. However, environmental restraint has been created by the use of code required locks on the doors leading to the lift and stairs on the upstairs level and on the door of the side entrance of the lower level.
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 restraint approval process is described in the restraint minimisation policy. The restraint coordinator is the CSM with a job description that defines their role and responsibility. An assessment and management process is documented for the use of both restraints and enablers which ensures the ongoing safety and wellbeing of residents. This includes cultural considerations. The restraint coordinator explained the process for determining approval, for recording, monitoring and evaluating any restraints or enablers used (refer to 2.1.1.4). Family/whānau approval is gained should any resident be unable to do so and any impact on family is also considered. This was evidenced by documentation and files viewed. Training for staff occurs at orientation and annually. The restraint coordinator also requires all staff to complete an annual restraint competency.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The restraint/enabler policy details the process for assessment. Assessment covers the need, alternatives attempted, risk, cultural needs, impact on the family, any relevant life events, any advance directives, expected outcomes and when the restraint will end. Completed assessment templates were sighted evidencing assessment, including consultation with family.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Policy describes that restraint and enablers are only used to maintain resident safety and only as a last resort. The restraint coordinator interviewed discusses alternatives with the resident, family/whānau and staff, for example low beds and sensor mats (refer to 2.1.1.4).

		Once approved and in use, the restraint is closely monitored and documented. Documentation includes the method approved, when it should be applied, frequency of checks and when it should end. It also details the date, time of application and removal, risk/safety checks, food/fluid intake, pressure area care, toileting, and social interaction during the process. Internal audits conducted measure staff compliance in following restraint procedures. A restraint register is maintained, updated monthly and reviewed by the restraint coordinator who shares the information with staff at the monthly quality, clinical and staff meetings.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	All restraints are reviewed and evaluated as per UCG policy and the requirements of the standard (refer to 2.1.1.4). The evaluation includes a review of the process and documentation, including the resident's care plan and risk assessments, future options to eliminate use and the impact and outcomes achieved. Family/whānau is included in the evaluation process. Evaluations are discussed at the monthly quality, clinical and staff meetings.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	A review of documentation and interview with the UCG national restraint coordinator and Rosedale CSM demonstrated the monitoring and quality review of the use of restraints. The national restraint coordinator analyses data, identifies trends and liaises with clinical staff as needed. The internal audit schedule was reviewed and included review of restraint minimisation processes. The content of the internal audits included the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff monitor adverse events while restraint is in use. Any changes to policies, guidelines, education are implemented if indicated. Data reviewed, minutes and interviews with staff including care staff and RNs confirmed that the use of restraint has reduced.

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 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	Ultimate Care Group has human resource management policies that are based on good employment practices and relevant legislation. Review of staff files evidenced four of the nine files did not have current performance reviews.	Staff performance appraisals are not consistently completed in the required timeframes.	Ensure all staff performances are completed in a timely manner. 180 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	PA Moderate	All residents’ medication charts audited had been reviewed by the GP three-monthly. However, in six out of fourteen medication charts reviewed, resident medication allergies and sensitivities were not documented. Medication fridge temperatures were recorded daily. A fan was being used in the upstairs medication room to cool it down. However, the temperature of the upstairs or downstairs medication rooms were not being monitored.	i) Information relating to residents’ allergies and sensitives is inconsistently documented. ii) The temperature of the two medication rooms is	i) Ensure that all allergies and sensitivities are documented on the medication chart. ii) Ensure that medication room temperatures are

legislation, protocols, and guidelines.			not being monitored.	recorded to support safe storage of medication. 180 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	Ultimate Care Group national office has developed a form to be used for documentation of each refrigerator and room temperature in the facility. This is to ensure temperatures meet the required guidelines. However, the form has not been implemented at the time of audit.	i) The temperature of refrigerators in residents' rooms are not monitored. ii) The chemical dispensers are not calibrated to ensure the dispensing units dispense the required amount to meet manufacturer's specifications.	i) Ensure residents rooms refrigerators temperatures are monitored. ii) Ensure all chemical dispensers are calibrated to dispense the required amount of chemical as per manufacturer's specifications. 90 days
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Moderate	Residents were observed to be moving freely around the facility. They reported that they were assisted to use the doors leading to the lifts by staff as needed. On the upper floor care unit there are doors separating the unit from the landing where the lift and the stairs are, code locks are in place on both sides of these doors. The code is written by the door at entry point, but not at exit point inside the care unit. The doors unlock automatically when a fire alarms sounds. One resident was seen to use the code to access the lift. One resident interviewed stated that they did not know how to get	Environmental restraint has been created by the use of code locks on two sets of doors in the facility which restricts entry and/or exit for residents, including into and from the areas	Ensure that residents are able to go through the doors exiting their care unit on the upper floor landing, and out through the side entrance door on the lower level at

		through the doors on their own as they did not know the code. Staff were observed using the code to enable residents to access the lift. There is also a code lock to exit the side entrance of the lower floor, however, residents are able to access the outside using the main entrance door.	where they live.	any time. 30 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.