Presbyterian Support Services Otago Incorporated - Aspiring Enliven Care Centre

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 BSI Group New Zealand Ltd, 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:	Presbyterian Support Otago Incorporated
Premises audited:	Aspiring Enliven Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 7 July 2021 End date: 8 July 2021

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: 48

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

Aspiring Enliven Care Centre is one of eight residential aged care facilities owned and operated by Presbyterian Support Otago (PSO). The service provides rest home, hospital and dementia levels of care for up to 52 residents. On the day of the audit there were 48 residents.

This certification audit was conducted against the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, a general practitioner and management.

Aspiring is managed by a registered nurse, who reports to the director of Enliven residential aged care services and is supported by a clinical coordinator. Organisational oversight is provided by the PSO Director of Enliven Services, the PSO quality advisor, and the PSO clinical nurse advisor. There are quality systems and processes being implemented. The service has been actively working on reducing the incidence of falls, reducing infections, enhancing the dining experience and improving activities.

Four areas of continuous improvement have been awarded around good practice, activities, food and nutrition, and infection control.

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.		All standards applicable to this service fully attained with some standards exceeded.

The manager and staff strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Information about the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is easily accessible to residents and families. Policies are implemented to support residents' rights. The personal privacy and values of residents are respected. Staff interviewed reflected their understanding of residents' rights.

Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. Complaints and concerns are promptly managed.

Organisational management

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

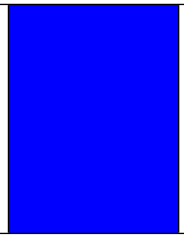
The director and management group of PSO provide governance and support to the manager. The quality and risk management programmes are guided by the service's philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents' meetings are held, and residents and families are surveyed annually.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported with actions implemented to prevent their reoccurrence.

Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. An orientation programme is in place for new staff that is specific to their job role and responsibilities. Ongoing education is being implemented, which includes in-service education, impromptu talks at handovers and competency assessments.

A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The electronic resident's file is integrated.

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.		All standards applicable to this service fully attained with some standards exceeded.

Prior to entry to the service, residents are screened and approved. The service's clinical coordinator and registered nurses are responsible for developing, maintaining and reviewing the care plans.

InterRAI assessment and risk assessment tools are used to assess the level of risk and ongoing support required for residents. Care plans are evaluated six-monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. The activity programme is varied and reflects the interests of the residents and includes outings and community involvement. The service has exceeded the standard in this area.

Medication policies reflect legislative requirements and guidelines. Staff responsible for the administration of medicines complete annual education and medication competencies. All meals are prepared on site. Individual and special dietary needs are catered,

and alternative options are available for residents with dislikes. A dietitian has designed and reviewed the menu. Regular audits of the kitchen occur.

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.

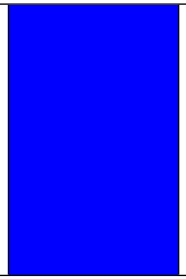
The service has implemented policies and procedures for fire, civil defence and other emergencies. The building warrant of fitness expires in September 2021. Rooms are individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. There is a main lounge, and dining room in both units with other smaller seating areas. There are sufficient bathrooms and showers. Fixtures, fittings and flooring are appropriate for the levels of care provided. Communal laundry is laundered off site at a commercial laundry. Cleaning and all laundry services are monitored through the internal auditing system. Chemicals are stored securely. The temperature of the facility is comfortable and constant, and able to be adjusted to suit individual resident preference.

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.

Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. At the time of the audit there were no residents with restraints or using an enabler. Staff training is in place to address restraint minimisation.

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.		All standards applicable to this service fully attained with some standards exceeded.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. There are Covid-19 alert level management plans in place and sufficient PPE is on hand. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted-upon, evaluated and reported to relevant personnel in a timely manner.

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	3	42	0	0	0	0	0
Criteria	4	89	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Discussions with ten staff (three registered nurses (RNs) including one clinical coordinator, four care workers, one maintenance, one activities coordinator, and one food services manager) confirmed their understanding of the Code and its application to their job role and responsibilities. A review of care plans, meeting minutes and interviews with five residents (one hospital and four rest home) and six relatives (one hospital, two rest home and three dementia) confirmed that the service functions in a way that complies with the Code. Observation during the audit confirmed this in practice.
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	The service has policies and procedures relating to informed consent and resuscitation directives. All seven resident files reviewed (one rest home respite, one rest home, three hospital and two dementia including one younger person disabled) included signed informed consent forms and advanced directive instructions. The resident or nominated representative signed admission agreements (sighted). Discussion with residents and families identified that the service actively involves them in decision-making.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on the resident's family/whānau and chosen social networks. Information is available regarding HDC advocacy services. Interviews with carers and the manager supports the carer's role as advocating for the residents.
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 and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain actively involved in the community and with external groups. Relatives and friends are encouraged to be involved with the service.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The PSO organisational complaints policy is being implemented. The manager has overall responsibility for ensuring all complaints (verbal and written) are fully documented and investigated. The manager maintains an up to date (electronic) complaints register. Concerns and complaints are discussed at relevant meetings. Two complaints were lodged in 2020 and only one complaint has been lodged in 2021 (year to date). All three complaints were reviewed. Acknowledgement of each complaint and an investigation and communication with the complainant was included in the register. All three complaints are documented as resolved. Corrective actions implemented include the purchase of additional call bell pagers and increasing the frequency of call-bell audits. Interviews with residents and relatives confirmed they have been provided with information on the complaints process.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code posters in English and te reo Māori, are on the walls in the hallways of the facility. The clients' right to access advocacy services is identified for residents with advocacy service leaflets available. Consumer rights information is provided to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope.
Standard 1.1.3: Independence,	FA	Policies that support resident privacy and confidentiality are being implemented. A tour of the facility

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.		confirmed there are areas that support personal privacy for residents. During the audit staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms and ensuring doors are closed while care is being undertaken. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences including cultural, religious, social and ethnic are identified during the admission and care planning process with evidence of family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings. Carers interviewed described how choice is incorporated into resident cares. There are policies, procedures and training in place that address elder abuse and neglect.
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 are policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Specialist advice is available and sought where indicated from local iwi and relevant providers of cultural services in the Wanaka community. The organisation's Enliven philosophy and approach means each person's cultural needs are considered individually. Training material is considerate of cultural sensitivity. Cultural needs are addressed in the resident's care plan, evidenced in one resident file of a resident who identifies as Māori. This resident was unable to be interviewed.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family is invited and encouraged to attend. Discussions with relatives confirmed that the residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. All staff are required to read and sign a code of conduct policy as part of the new employee induction process. Two-monthly staff meetings include discussions on professional boundaries and concerns as they arise. The manager provides guidelines and mentoring for specific situations. Interviews with staff confirmed their awareness of professional boundaries.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	All Presbyterian Support Otago (PSO) aged care facilities have a master copy of policies, which are developed in line with current accepted best practice and are reviewed regularly. The content of policies and procedures are sufficiently detailed to allow effective implementation by staff. Presbyterian Support Otago's (PSO) quality plan (July 2021 – 2022) supports good practice. The six principles for PSO Enliven residents cover respect, relationships, security, choice, contribution and activity. One principle is reviewed each month with examples provided on how the principle can be put into practice by staff. The service monitors its performance through its benchmarking programme with other PSO aged care facilities and externally with other similar New Zealand based aged care providers. Performance is also monitored via residents' meetings, staff appraisals, satisfaction survey results, staff education and competencies, the complaints process and incident management. Staff orientation covers general and job-specific orientation. A physiotherapist is on site three hours per week. A general practitioner (GP) (from two local family health centres) visits the facility two days per week with on-call service provided after hours. The achievement of the rating that the service provides an environment that encourages good practice is beyond the expected full attainment.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to record family notification. Incident forms reviewed (17) indicated family were informed. Relatives interviewed confirmed they were notified of changes in their family member's health status. Interpreter services are available as needed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Aspiring Enliven Care Centre, located in Wanaka, is one of eight aged care facilities under Presbyterian Support Otago. They provide care for up to 52 residents. The Cardrona unit is a 32-bed rest home and hospital unit (all dual-purpose beds) and Hawea is a 20-bed secure dementia unit. During the audit there were 48 residents living at the care centre (12 rest home level, 20 hospital level and 16 dementia level). One resident (rest home level) was on respite for palliative care and one resident (dementia) was funded under the young person with a disability (YPD) contract. All remaining residents were under the age-related residential agreement.

		The director of Enliven Services, PSO quality advisor and PSO clinical nurse advisor provide direction and support to the manager/RN and clinical coordinator/RN. PSO has a current strategic plan, and a 2020-2021 quality plan that is being implemented. The 2021-2022 quality plan has been drafted and is awaiting ratification by the board. There are specific and measurable goals developed for the Aspiring Care Centre that have been developed in conjunction with one other PSO Enliven care centre location in Wanaka, Elmslie House. Quality goals are reviewed a minimum of quarterly. The manager/RN is responsible for the oversight of the care centre. She is a registered nurse with 30 years of experience, predominately in aged care. She has been in the role since March 2020 and has worked for PSO for the past 10 years with five years of experience at Elmslie House. She is supported by a clinical coordinator/RN who previous to this role was a staff RN. She has been in her role in a permanent position since September 2020. The manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility.
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	During the temporary absence of the manager, the clinical coordinator oversees the facility with support from the PSO quality advisor, PSO clinical nurse advisor and the manager/RN at PSO Elmslie House.
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	The PSO Enliven Services quality plan describes the organisation's philosophy and four domains of quality and risk management. Ten measurable quality objectives are described in detail. Progress is documented in the quarterly quality report. These objectives are discussed at PSO management/quality meetings and information then feeds to staff in the staff meetings. Discussions with RNs and carers confirmed their involvement in the quality programme. The service has policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Resident/relative meetings occur monthly. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement. A resident survey and a family survey are conducted annually with the most recent survey completed in quarter three (January to March 2021). Survey results evidence that residents and families are overall either very satisfied or

		satisfied with the service. Continuous quality improvement is an objective on the quality plan. A log of quality initiatives is documented and signed off when achieved. Quality indicator data (e.g., falls, behaviours of concern, skin tears, medication errors, polypharmacy, pressure injuries, restraint use, infections by type) are benchmarked against all PSO aged care facilities and other PSO organisations. Data is also being benchmarked with other New Zealand aged care facilities external to Presbyterian Support. Presbyterian Support has a robust health and safety commitment. There is a central health & safety committee that has representation from all PSO services including the eight Enliven Care Homes, Support Centre and Family works staff. Elmslie House has a combined health and safety committee with Aspiring Enliven, also located in Wanaka. Health and safety objectives (7) are posted in the staffroom. Health and safety meetings are scheduled two-monthly. All committee members have completed health and safety training. Staff and contractors are orientated to health and safety. Staff training continues annually. Health and safety is a regular agenda item in meeting minutes. A range of falls prevention strategies are being implemented (link CI 1.1.8.1).
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	There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Incident and accident data is collected, analysed and benchmarked through the PSO benchmarking programme. A sample of 17 resident adverse event reports were reviewed using the VCare electronic programme. This included witnessed and unwitnessed falls, skin tears, pressure injury, bruising, and medication errors. Appropriate clinical care was provided following an incident, including neurological observations for unwitnessed falls or if there was a suspected injury to the head. The manager is aware of her responsibilities in regard to essential notifications for one outbreak (6 January 2020); and special dispensation for a PG level resident in the dementia wing (link CI 1.1.8.1).
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements	FA	The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is retained for the RNs, physiotherapist, podiatrist, pharmacy, GPs, and nurse practitioners (NPs). There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files were reviewed (one clinical manager, two RNs, four care workers, one kitchen assistant and one activities coordinator). All files included evidence of a signed

of legislation.		employment agreement, job description, reference checking and police vetting. Annual appraisals are conducted for all staff. A comprehensive education and training programme for staff is being implemented. Education records reviewed for 2020 and 2021 (year-to-date) evidenced that training is provided by the way of education sessions, and mini-education sessions (tool box talks) conducted at handover. A range of competencies are completed relevant to the position of the employee including (but not limited to) medication management, syringe driver, manual handling, restraint minimisation. Staff complete in excess of eight hours of education per year. There are 13 RNs employed (including the manager and clinical coordinator). Five have completed their interRAI training. The RNs are able to attend external training including conferences, seminars and sessions provided by PSO and the local district health board (DHB). Thirty-six carers are employed. Fifteen work in the dementia unit. Eight have completed their dementia qualification and the remaining seven who have worked in the unit for less than eighteen months are enrolled. Out of the total of 36, 14 have completed a level three Careerforce qualification (or equivalent) and eight have completed a level four Careerforce qualification (or equivalent).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Aspiring Enliven Care Centre has a four-weekly roster in place that ensures there is sufficient staff rostered on. There is a full-time manager/RN who works Monday - Friday and a part time clinical coordinator/RN (24 hours per week) (Monday, Tuesday, Thursday). In the Cardrona rest home/hospital unit (12 rest home level and 20 hospital level residents) there is one RN on the morning, afternoon and night shifts. Five carers (three long shift and two short shifts [to 1300 and 1330]) are scheduled to work during the morning shift, four carers (two long shift and two short shifts (1500 – 2130 and 1700 – 2100) on the afternoon shift and one carer on the night shift. In the Hawea dementia unit (16 residents) there is one RN that covers the morning shift (Monday – Friday). Three (long shift) carers are rostered to work during the morning shift, three carers (two long and one short to 2030) on the afternoon shift and one carer on the night shift. Staffing is adjusted to meet the acuity of the residents (link CI 1.1.8.1). The manager and clinical coordinator provide on-call cover afterhours and on weekends. Interviews with staff, residents and family identify that staffing is adequate to meet the needs of residents.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed within this time. Residents' files are protected from unauthorised access by being locked away in cupboards within the nurses' station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries are legible, dated and signed by the relevant care workers or RN, including designation.
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	All residents are assessed prior to entry to the facility. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code of rights, advocacy and complaints procedure. There is a comprehensive admission booklet available to all residents/family/whānau on enquiry or admission. The information includes examples of how services can be accessed that are not included in the agreement. Relatives agreed that the service was proactive with providing information. The clinical coordinator and manager interviewed were able to describe the entry and admission process. The GP is notified of a new admission. Signed admission agreements were sighted and align with the ARC contract.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form, and the completed form is placed on file. The service states that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation, for example, GP letter, medication charts, care plans, are copied and forwarded with the resident.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	FA	There are medication management policies and procedures in place, which follows recognised standards and guidelines for safe medicine management practice. All medications were stored securely. Medications are checked as part of a monthly medication audit. All eye drops were dated at opening. No expired medications were noted on any trollies or medication storage shelves. A medication round was observed in the rest home/hospital wing and the registered nurse followed procedure that was correct and safe. A medication round was also observed in the dementia unit

guidelines.		and the care worker also followed safe and correct administration procedures. The service uses an electronic medication system and charting and administration. All prescribing and administration requirements were adhered to in the 14 medication charts reviewed (four rest home, six hospital and four dementia residents). The self-medicating policy includes procedures on the safe administration of medicines. Currently one respite resident self-administers. The resident's self-medicating competency was completed on admission. The resident manages safe and secure storage of medications.
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 large, well-equipped kitchen and all meals are cooked on site. The service also provides food service to another PSO home in Wanaka and provides a 'meals on wheels' service to the community. Kitchen fridge, chiller, freezer and meal temperatures are recorded, and action is taken as needed. The kitchen was observed to be clean and well organised. The food control plan has been audited and the kitchen is certified until 1 February 2022. A registered dietitian is employed by Presbyterian Support Otago (PSO) and there is dietitian input into the provision of special menus and diets where required. A full dietary assessment is completed on all residents at the time they are admitted. The dietitian reviews residents with weight loss everyone to two months. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically, as part of the care planning review process. Residents are referred to the dietitian if they have had a 10% change in body weight. A nutritional assessment is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture required. Resident meetings discuss food as part of their meetings. Residents and relatives expressed satisfaction with meals provided. The service has implemented an improvement in meal satisfaction. The service has exceeded the standard in this area. Special equipment is available. Internal audits are undertaken, and the food service manager was able to describe the audit processes.
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	FA	The reason for declining entry to the service is recorded and should this occur, the service stated it would be communicated to the family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.

organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All long-term residents are admitted following a need's assessment and service coordination team prior to admission. The interRAI assessment tool forms that basis of the long-term care plan as well as other risk assessments dependent on resident needs. The manager, the clinical coordinator and three registered nurses are interRAI trained. Risk assessments are all completed on the electronic resident management system and included falls, pressure risk, dietary needs, continence and pain. The outcomes of these assessments were reflected in the care plans reviewed. Pain assessments were evidenced as completed with ongoing monitoring recorded for residents requiring administration of controlled medication as part of prescribed pain management plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans reviewed reflect the interRAI assessment process and the risk assessments completed. Six of seven resident files reviewed included use of the new 'My Care Plan' long term care plan. One resident was on respite care. The new 'My Care Plan' template incorporates the activities and social profile, and activities plan and is very resident focused with sections that are written in the first person to reflect the residents needs and requirements. The staff interviewed advised that they like the new care plan template as it is easy to read and understand. The respite rest home resident has a short-term care plan in place. All care plans reviewed have been comprehensively completed to reflect the assessed needs. Presbyterian Support Otago has a full range of policies and procedures to support staff to support and care for residents. Short-term care plans (STCPs) are used for short term and acute conditions. All seven resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Residents' files reviewed were integrated and include (but not limited to) input from GP, physiotherapist, dietitian, and nursing/caring.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The care provided is consistent with the needs of residents as demonstrated on the review of the care plans, discussion with family, residents, staff and management. Dressing supplies are available, and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-service and wound management in-service has been provided as part of annual training. The registered nurses

		and clinical coordinator interviewed were able to describe access to specialist services if required. Wound assessment and wound management plans are in place for 10 residents in the rest home/hospital wing and one resident in the dementia wing. Wounds included removal of lesions, skin tears, corns, a burn and a punch biopsy. The podiatrist has been involved in three resident wounds. There were no residents with pressure injuries. All wounds have documented assessments, treatment plans and wound evaluations documented. Monitoring charts were in use (but not limited to) food/fluid, weights, bowel, behaviours and pain.
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.	CI	PSO Aspiring Enliven employs an activities coordinator and an activities assistant who work a combined 60 hours per week providing activities over Monday to Sunday. The activities staff are supported by volunteers for various activities. The activities coordinator has been in the role for nine months and is enrolled to complete dementia specific unit standards. There are two separate programmes – one for Cardrona wing (rest home and hospital level residents) and one for Hawea wing (dementia level residents). On admission, a social profile is recorded in conjunction with the resident and family members. This forms the basis of the 'getting to know me' and 'interactive me' sections of the care plan. Reviews are conducted six-monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed monthly. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered. The service has worked on improving the satisfaction of the activities programme and has exceeded the standard in this area. The service shares a van with the other PSO facility in Wanaka. The activities coordinator has a current first aid certificate. Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. Resident meetings are held monthly and feedback on the activities programme is encouraged at the meetings and through surveys. The activities coordinator facilitates zoom meetings with dementia resident's family members who are not able to visit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long term care plans reviewed included six monthly evaluations. The long-term care plan evaluations are recorded on the electronic care plan and are updated as required as evidenced in the files reviewed. The service conducts MDT meetings with each department represented. InterRAI reassessments and review of risk assessments is also completed six-monthly. A review of medical notes identified GPs have completed reviews at least three-monthly. Short-term care plans were in

		use for acute changes in health status.
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 services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and/or their family/whānau are involved as appropriate when referral to another service occurs. The registered nurse and nurse manager interviewed described the referral process and related form should they require assistance from a wound specialist, continence nurse, speech language therapist, nurse practitioner and dietitian.
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	The infection control manual contains documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes a policy around safe storage and handling of chemicals. Waste is appropriately managed. Chemicals are secured in designated locked cupboards. Chemicals are labelled and safety datasheets were available in the laundry and sluice areas. Safe chemical-handling training has been provided. Personal protective equipment is available for staff.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service building warrant of fitness is current and expires on 30 September 2021. A preventative building maintenance-programme ensures that all legislation is complied with. A maintenance-work notification book is available for staff to communicate with maintenance person who works two days per week at the service. A contractor attends to the gardens. The facility maintenance schedule is coordinated by the PSO property manager. An annual inspection and walk around of the facility are conducted with the manager to identify any areas that require attention. Hot water temperatures are monitored and recorded monthly. The environment and buildings are well maintained. The maintenance person is available afterhours, if required. Electrical equipment is tested and tagged. All medical equipment has been calibrated and checked. The facility van is registered and has a current warrant of fitness. Corridors within each wing are of sufficient size to allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails are appropriately located. There is an internal courtyard area with seating, tables and shaded areas in the dementia unit that are easily accessible. External seating areas, pathways, seating and grounds appear well maintained. All hazards have been identified in the hazard register.

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 32 resident rooms in the rest home/hospital wing (Cardrona) and 20 resident rooms in the dementia unit (Hawea). Four resident rooms in the Cardrona wing have shared bathroom facilities, and two rooms in the Hawea wing have shared bathroom facilities. Privacy is ensured. Additional resident toilet facilities are available near the lounge and dining areas. Resident rooms have hand-washing facilities with soap dispensers and paper towels. Staff and visitor toilets are also provided.
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	Residents' rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents between rooms can occur in resident's bed and equipment can be transferred between rooms. Mobility aids can be managed in communal toilets and showers. Residents and relatives confirmed satisfaction with their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The Cardrona wing has a large communal dining room and a large lounge. The Hawea wing has a large dining room and two lounges plus another quiet sitting area. There are smaller seating areas around the facility for residents and families. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounges, dining room, activities room and courtyards and this was confirmed by staff and residents interviewed.
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	All communal laundry is completed off site. Resident's personal washing is completed on site. Residents and relatives expressed satisfaction with cleaning and laundry services. Staff could describe the dirty to clean flow. The service has secure cupboards for the storage of cleaning and laundry chemicals. Chemicals are labelled. Material safety datasheets are displayed in the laundry and also available in the chemical storage areas. Laundry and cleaning processes are monitored for effectiveness and compliance against the service

		policies and procedures. Cleaning and laundry staff have completed chemical safety training.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency management plans are documented to ensure health, civil defence and other emergencies are covered. Appropriate training, information and equipment for responding to emergencies are part of the orientation of new staff. There is an emergency management manual and a fire and evacuation manual. The service has implemented policies and procedures for civil defence and other emergencies. The service has an approved fire evacuation scheme. Fire evacuation drills take place every six months, with the last fire drill occurring on 28 April 2021. At least one staff member is on duty at all times with a current first aid certificate. There is sufficient water stored (including a 5200-litre water tank) to ensure for three litres per day for three days per resident. Alternative heating and cooking facilities are available. Civil defence kits are stocked and checked six-monthly. Emergency lighting is provided by way of battery backup. Call bells are situated in communal areas, bedrooms and bathrooms. The system has staff pagers and a call bell light panel in each nurses' station. Recent enhancements have been made to the call bell system (link CI 1.1.8.1). Staff conduct regular checks on residents within the facility and ensure that the facility is secure at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and resident rooms are appropriately heated and ventilated. There are radiator heaters in each room and temperatures can be individually adjusted. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas.
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	PSO Aspiring Enliven has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The PSO clinical nurse adviser is the designated infection control nurse for the organisation, with the manager as the infection prevention and control coordinator for the facility. Infection control is linked to the quality meeting and includes discussion and reporting of infection control matters. The infection control programme has been reviewed annually. Minutes of meetings are available for staff. Education is provided for staff as part of the service education programme.

		The PSO clinical nurse advisor is part of the Southern DHB aged care locality lead working group which met frequently during Covid lockdown and since. The service has well developed plans for contingency with regards to the various Covid-19 alert levels. There are sufficient supplies of PPE on hand, and training around infection control, hand hygiene, and donning and doffing of PPE has been provided to staff. Isolation kits are available for use and the service is currently facilitating vaccination of staff and residents.
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	There are adequate resources to implement the infection control programme, for the size and complexity of the organisation. The infection control (IC) nurse is the clinical adviser for the organisation. The clinical adviser maintains her practice and has completed training. Aspiring Enliven has external support from the local laboratory infection-control team, Public Health South, the aged residential care infection control nurse employed by the Southern DHB, and the local hospital. Staff interviewed are knowledgeable regarding their responsibilities for standard and additional precautions.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	Infection control policy and procedures are appropriate to the size and complexity of the service. Infection control is one of the CQI groups within PSO. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by the organisation and are reviewed and updated annually.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. The clinical nurse advisor and external providers, who provide the service with current and best practice information, facilitate this. All infection control training is documented, and a record of attendance is maintained. Discussion of infection prevention is documented in resident meeting minutes.

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.	CI	Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection surveillance policy. Monthly infection data is collected for all infections. The PSO infection prevention and control (IPC) nurse receives surveillance data that is collated monthly, including strategies for corrective actions. An infection report and short-term care plan is available for recording infections. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly, three monthly and annually. The service has exceeded the standard in this area. Outcomes and actions are discussed at staff and management meetings. A three-monthly infection report is provided to the PSO clinical governance group. Infection rates are benchmarked with two other Presbyterian Support services in the lower South Island. If there is an emergent issue, it is acted-upon in a timely manner. Reports are easily accessible to the manager and to organisational management. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The manager is the restraint coordinator. The facility has maintained a restraint free environment since April 2021. Staff training is in place around restraint minimisation and management of challenging behaviours. This training begins during their orientation to the service and continues annually.

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.

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred, which is beyond the expected full attainment.	Quality improvement projects that have been implemented and exceed what is expected include reviewing if each improvement has had a positive impact on resident safety and/or resident satisfaction. Examples include: 1) Falls prevention strategies being implemented include (but not limited to): falls risk assessment for residents at risk, medication reviews, education for staff, reducing residents’ medications, physiotherapy input, frequent increased supervision and sensor mats if required. A list of residents who are at a higher risk of falling is documented and visible for staff. A falls champion group is implemented. Interviews with the carers confirmed their understanding in relation to falls prevention strategies. They were very aware of which residents were at high risk of falling and could describe specific strategies to reduce falls for each particular resident. Falls at Aspiring were over the benchmark as reported in the falls group meeting in February 2021. And since this time, with a refocus on falls prevention, falls have gradually reduced below the benchmark: April: 9.9 falls per 1000 bed nights (hospital); 12.7 falls (rest home); 9.0 falls (dementia), May: 10.4 falls (hospital); 6.4 falls (rest home); 5.9 falls (dementia) and June 4.9 falls (hospital); 0 falls (rest home); 14.6 falls (dementia).

			2) Improved response to call bells: In response to one complaint received around responding to call bells the facility purchased additional equipment to improve communication between staff in the event they are not able to answer a call bell and need to ask for assistance. A robust (weekly) monitoring of the call bell log and interviews with residents confirmed that the staff are now doing a very good job of answering call bells in a timely manner. The resident who lodged the complaint is also pleased with the staff's response to a call bell alert. 3) Reducing the incidences of residents who have behaviours to cause concern. Specific strategies are implemented to address residents in the dementia unit who are reassessed for a higher level of care (D6) but, with approval by the Ministry, remain in the D3 dementia unit until a suitable bed is located in a D6 approved facility. One specific example resulted in staff seeking additional input from the mental health team at Dunedin Public Health, the crisis team at Dunstan and input from a palliative nurse practitioner and specialist. Extra staff hours are rostered for 'specialling' to ensure all residents were kept safe. Time was spent with families to help them understand the situation. 4) Multi-disciplinary meetings (MDT) are scheduled once a month to address residents that need more input and require the MDT team's input. External health professionals who attend, in addition to in-house staff include a GP, nurse practitioner (NP), hospice NP and RN, mental health team, and pharmacy advisor) with ideas formulated to create a 'best plan' to enhance residents' quality of life and well-being. Two-three cases are discussed each month and have focussed on medication and polypharmacy. Since these meetings have begun polypharmacy has decreased as well as residents' falls.
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	CI	Food satisfaction is part of the annual survey conducted with residents and family members. Food and meal services is discussed at residents' meetings and feedback is welcomed.	The 2020 residents survey identified some dissatisfaction with the food service. A foodie's group was established with representatives from staff including manager and food services manager, residents and relatives to discuss issues and solutions around food preparation and presentation. Corrective actions included improving the presentation of meals and changing some meat option on the menu as requested by residents. The food service manager has developed presentation photo cards for each main meal so that staff can easily and quickly see how the meal should be presented. Procurement of some meat has changed to improve eating experience. As a result, the 2021 resident satisfaction survey showed an improvement from 50% to 92% satisfaction with the standard of meals, and an increase in the relatives' survey in relation to meal

			standard from 73% to 93% satisfaction.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The activities programme is interesting and varied. Feedback about the programme is included in annual surveys and at resident meetings. The 2020 residents and relatives survey identified lower rates of satisfaction with the activities programme in terms of a meaningful range of activities offered, enjoying the range of activities and around having the opportunity to participate in activities outside the home. A corrective action plan was developed and implemented. The 2021 resident and relative survey evidenced higher levels of satisfaction with the activities programme. Residents interviewed also expressed their enjoyment of the programme.	The 2020 resident satisfaction survey showed that 67% of resident responses agreed that they were offered a meaningful range of activities, 66% stated that they enjoyed the range of activities, 66% stated that the activities of cultural and spiritual relevance are treated with respect, 66% stated that they have the opportunity to participate in activities outside the home. The 2020 relatives survey had similar results and levels of satisfaction. The service developed corrective actions to address the issues raised including ensuring that residents and relative have a greater awareness of the activities that are occurring within the home, having an activity board to promote activities, having the Enliven Philosophy principles promoted each month, redesigning the resident's library, sending out weekly schedules to residents and relatives, and providing relatives with photos of the residents participating in activities. The 2021 residents and relatives survey conducted identified an increase in satisfaction with the activities programme. In response to the statement "I am offered a meaningful range of activities", 82% agreed, 91% stated that they enjoy the range of activities available, 100% stated that the activities of cultural/spiritual nature were treated with respect, and 83% stated that they have the opportunity to participate in activities outside the home. The relatives survey results for 2021 reflected similar increases in satisfaction.
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are	CI	The service benchmarks infection data with other PSO homes and with other Presbyterian Support services in the lower South Island. Each month data is collected relating to rates of infections relating to respiratory tract, wound, skin, and urinary tract.	In the early part of 2020, it was identified that urinary tract infections for rest home residents was above the acceptable rate six times in the past 12 months. The service developed a corrective action plan which included education and training for staff, promoting a urinary tract infection prevention information board, and education for residents and family members. As a result, since August 2020 there have been no urinary tract infections reported for rest home residents. Similar results were noted for residents in the dementia unit with urinary tract infection rates above the KPI mark five times in the 12 months leading up to December 2020. Since then, and as a result of quality improvement actions, no urinary tract infections have been reported for 2021, year to date.

acted upon, evaluated, and reported to relevant personnel and management in a timely manner.			

End of the report.