

# Heritage Lifecare (BPA) Limited - Flaxmore Care Home

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## 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 The DAA Group 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:** Heritage Lifecare (BPA) Limited

**Premises audited:** Flaxmore Care Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 26 January 2022      End date: 27 January 2022

**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:** 28

# Executive summary of the audit

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## 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

Flaxmore Care Home (Lifecare) provides dementia care services for up to 47 residents.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included the review of policies and procedures, review of residents' and staff files, observation, and interviews with family members, managers, staff, and a nurse practitioner.

The residents and family members spoke positively about the care provided.

There were no areas requiring improvement identified as part of this audit.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Flaxmore Lifecare when they are admitted. Opportunities are provided to discuss the Code, consent, and availability of advocacy services at the time of admission and thereafter as required.

Services are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for any residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required and bi-lingual staff.

Flaxmore Care Home has linkages to a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

Information about the complaints process is provided at the time of admission and is available at the front entrance. Complaints are being fully investigated and responded to.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Heritage Lifecare (BPA) Limited is the governing body and is responsible for the services provided 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 reporting to the regional manager, operations and quality manager, and head of care and quality manager.

The facility is managed by a care home manager, who has a master's in business administration and has been in this position since July 2021. The clinical manager has experience in aged care and has been in the position since December 2021. The clinical manager is responsible for the oversight of the clinical services in the facility.

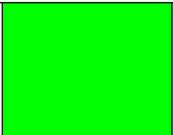
There is an internal audit and quality programme. Risks are identified and a hazard register is in place. Adverse events are documented on an electronic accident/incident form. Facility meetings are held where there is reporting on various clinical indicators, quality and risk issues, and discussion on identified trends.

There are policies and procedures on human resources management. A mandatory education programme is provided for staff.

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

The privacy of resident information is maintained. The name and designation of staff making entries in clinical files are recorded and legible.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents' admission to the facility is appropriate and efficiently managed with liaison evident between the Needs Assessment Service Coordination (NASC) and the clinical team. Relevant information is provided to the potential resident and their family to facilitate admission to the facility.

The residents' needs are assessed by the multidisciplinary team on admission and within the required time frames. Care plans are individualised, based on a comprehensive range of information, and accommodate any new problems that might arise. The residents' files reviewed evidenced that the care provided and the needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health providers as required. Shift handovers and communication sheets promote continuity of care between the shifts in each of the units.

The planned activity programme is delivered by one full time and one part time activities assistant, spread across the three clinical areas. The activities programme provides a variety of individual and group activities and maintains the residents' links with the community as much as Covid-19 allows. There is a facility vehicle available for outings.

Medicines are managed according to the policies and procedures which are based on current best practice and consistently implemented. Medications are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with any special requirements catered for. There is food available for residents 24 hours a day. Policies guide the food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents and families verified satisfaction with the meals provided.

## Safe and appropriate environment

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

There is a reactive and preventative maintenance programme, including equipment and electrical checks. Fixtures, fittings, and floor and wall surfaces are made of suitable materials for this environment.

Residents' bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids, and to allow for care to be provided. Lounges, dining areas, and sitting alcoves are available for residents and their visitors. External areas and gardens are safe for residents to mobilise around.

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

Protective equipment and clothing are provided and used by staff. Chemicals are safely stored. The laundry service is conducted off-site. Cleaning of the facility is conducted by household staff and monitored for effectiveness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the clinical nurse manager who is a registered nurse.

On the day of the on-site audit, there were no restraints in use. Restraint is only used as a last resort when all other options have been explored.

Staff receive education relating to the use of and management of restraints.

## 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 prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed if required.

Staff demonstrated good knowledge around the principals and practice of infection control, guided by relevant policies and supported with regular education.

Age care specific infection surveillance is undertaken, with data analysed, benchmarked and results reported through to all levels of the organisation. Follow up action is taken as and when required.

Covid-19 related processes are in place to manage the changes in the Ministry of Health Covid-19 response levels.

## 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Flaxmore Lifecare has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). This is displayed throughout the facility in both English and 'te reo Māori' and residents family/whānau receive a copy of this in the admission pack. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is compulsory for all staff as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principals and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs and outings. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents is defined and documented, as relevant, in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>All residents' files reviewed have an enduring power of attorney (EPOA) in place and these</p>

		<p>have been activated.</p> <p>There is one resident with English as a second language although they can understand what is being said. Several staff are bi-lingual and interpreter services are available. All families were well informed as per the family communication sheet, incident forms and interviews.</p> <p>Staff were observed gaining day to day consent on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the service are on display in the reception area of the facility. Family members of residents that were spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff are also aware of how to access the Advocacy Service if this is required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending outings, visits, activities, and entertainment, as current Covid-19 restrictions allow. The facility encourages visits from family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Policies and procedures relating to complaints management are compliant with Right 10 of the Code. Systems are in place that ensures residents' families are advised on admission to the facility of the complaint process and the Code. The complaints forms are displayed and accessible within the facility. Staff interviewed confirmed their awareness of the complaints processes. Families demonstrated an understanding and awareness of these processes.</p> <p>The care home manager (CHM) is responsible for complaints management. A complaints register is maintained.</p> <p>The register noted one complaint closed in 2021. This related to the behaviour of a resident who was reassessed and required a higher level of care and was transferred to a more suitable facility (refer 1.2.4).</p>

		<p>The facility maintains a minor concerns book to document any family member's concerns. Nine concerns were recorded in 2021 and one in 2022. All had been investigated and closed in a timely manner.</p> <p>One complaint had been received from the DHB, in 2021, regarding a family complaint of missing clothing. This was investigated by the DHB and closed with no further action required.</p> <p>There were no other complaints currently with any other external agencies.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>When interviewed, the family/whānau of Flaxmore Lifecare residents, reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in English and te reo Māori at the reception and throughout the facility and each resident has a copy of this in the admission folder. Information on how to make a complaint and provide feedback is available and displayed in the reception area.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and their families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to the personal cares of residents, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families. All residents have a private room with a wash basin. There is a lounge and dining area located in each wing, providing residents with an area to eat and watch television.</p> <p>Residents are encouraged to maintain their independence by participating in activities within the facility. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs have been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the services policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to be occurring during the orientation and annually.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are currently three residents at Flaxmore Lifecare that are of Māori descent, but do not identify with their culture. Recognition of Māori culture has been identified by the senior management as an area requiring further development and a corrective action plan has been put in place and education arranged for staff, to enable them to support any future residents who do identify as Māori to integrate their cultural values and beliefs. The principals of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau. There is a current Māori health plan and guidance on tikanga best practice is available and there are staff that can act as a resource.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Staff can access an external interpreter service for residents if required and several staff members are bi-lingual. Residents' personal preferences required interventions and special needs were included in all care plans that were reviewed. For example, likes and dislikes and attention to preferences around activities of daily living.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. An allied health professional who was interviewed also expressed satisfaction with the standard of services provided to the residents. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. 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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service provides and encourages good practice. This is demonstrated through evidence-based policies, input from external specialist services and allied health professionals, for example a physiotherapist, wound care nurses, dieticians, podiatrist, and education for staff. The nurse practitioner (NP) confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported that they receive management support for external education and access</p>

		their own professional networks.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's status, they were advised in a timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the family communication sheets in the residents' records that were reviewed. There was also evidence of resident/family input into the care planning process and the multi-disciplinary meetings. Staff understood the principals of open disclosure, which was supported by policies and procedures that meet the requirements of the Code. Staff knew how to access an interpreter should this be required, and several staff members are bi-lingual.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Flaxmore Care Home (Flaxmore Lifecare) is part of The Heritage Lifecare Limited (Heritage). The Heritage executive management team provides support to the facility. The care home manager (CHM) provides the executive management team with monthly progress against identified indicators.</p> <p>There is a clear mission of the organisation with values and goals (The Heritage Way) and these are communicated to staff and family through posters at the entrance to the facility and in information booklets.</p> <p>The care home manager (CHM) is responsible for the overall management of the service and has been in this role since July 2021. The CHM has completed a master's in business administration and was the administrator at the facility for four years before accepting the CHM position. Since accepting the role they have completed an Alzheimer's New Zealand education course, enrolled in a Careerforce dementia care course, and the online DHB dementia care course.</p> <p>The CHM is supported by a clinical nurse manager (CNM) who is responsible for the oversight of clinical services. The CNM is an RN with experience in aged residential care and has been at the facility since December 2021. The required authorities have been informed.</p> <p>The facility can provide care for up to 47 residents with 28 beds occupied on the day of the audit.</p> <p>- 28 residents requiring D3 dementia level care, this included: -one resident on respite D3 dementia level care,</p>

		<p>-and one resident under the age of 65 years.</p> <p>The facility has a contract for Dementia D3 level care, respite care and can provide day care. Day care services are currently not being utilised.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the CHM, the CNM is delegated to perform this role, with support from the regional manager. For any extended period of level, the Heritage management team will provide support and cover.</p> <p>A senior registered nurse will be appointed to provide oversight of clinical care when and if required.</p> <p>Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Flaxmore Lifecare uses the Heritage quality and risk management framework that is documented to guide practice.</p> <p>The service implements organisational policies and procedures to support service delivery, including policies on interRAI. At audit, it was noted several forms and documents required reviewing 2017. Discussion with the CHM confirmed the support office has a corrective action plan in place to address all policies and forms that require review. The plan includes the support office reviewing policies based on a traffic light system with input from a policy development specialist. The CHM confirmed policies of high risk to the organisation and residents have been reviewed as per the traffic light system.</p> <p>Policies and forms are being aligned and reviewed to the 2021 Health and Disability Services Standards, current and applicable legislation, and evidence-based best practice guidelines. Policies are readily available in hard copy for staff. New and revised policies are introduced to staff at meetings and policy updates are also presented as part of relevant in-service education, sighted at audit. Staff interviewed confirmed that they are alerted to new and revised policies and receive opportunities to read and understand the policies.</p> <p>Service delivery is monitored through complaints, review of incidents, key performance indicators, and implementation of an internal audit programme. Clinical indicators are collated monthly and benchmarked against other Heritage facilities.</p> <p>The internal audit programme is documented and implemented as scheduled. Internal audits cover all aspects of the service and are completed by the relevant staff member.</p>

		<p>Audit data is collected, collated, and analysed at the facility. Results are reported to the Heritage support office. Interviewed staff reported that they are kept informed of audit activities and results at staff meetings.</p> <p>Satisfaction surveys for residents and families are completed as part of the internal audit programme on a six-monthly basis. Interviews with staff, and family confirmed a satisfaction survey was completed. The October 2021 survey had been collated, analysed and communicated to staff and family as evidenced in meeting minutes and interviews.</p> <p>Facility meetings are conducted, for example, staff, quality health and safety, and infection prevention and control meeting, RN meetings, and family meetings. Minutes of meetings evidenced communication with staff around aspects of quality improvement and risk management.</p> <p>Flaxmore Lifecare has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There was evidence of hazard identification forms completed when a hazard was identified. The CHM is responsible for maintaining the hazard register. The CHM is the health and safety (H&amp;S) officer until the permanent H&amp;S officer returns from overseas.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff understood the adverse event reporting process and were able to describe the importance of recording near misses. Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. The RN enters the accident/incident into the electronic management system. Accident and incident forms are reviewed by the CNM and CHM and signed off when any corrective actions have been completed. The RNs undertake assessments of residents following an accident. The CNM discussed the process of completion of neurological observations and falls risk assessments to be completed following accidents/incidents when appropriate.</p> <p>Policy and procedures comply with essential notification reporting, for example, health and safety, human resources, and infection control. The CHM and CNM are aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility, unexpected deaths, sentinel events, notification of a pressure injury, infectious disease outbreaks, and changes in key clinical managers.</p> <p>There was a total of twenty 'section 31' notifications in 2021 with authorities notified as required.</p> <p>This included:</p>

		<ul style="list-style-type: none"> <li>- December 2021 respiratory viral outbreak that was contained</li> <li>- frequent reports of two residents' behaviour that required reassessment and transfer to a higher level of care,</li> <li>- one resident transferred to DHB following a fall, investigations note no fracture.</li> </ul>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practices, and relevant legislation. A sample of staff records reviewed confirmed the organisation's policies are consistently implemented and records are maintained.</p> <p>The CHM discussed and acknowledged the recent high staff turnover. The CHM has instigated new communication methods and completed a staff survey (December 2021) that still requires collation and analysis. At interview new and existing staff reported favourably on the new management and the open-door policy.</p> <p>Professional qualifications are validated. There are systems in place to ensure that annual practising certificates are current. Current certificates were evidenced in reviewed records for all staff and contractors that required them.</p> <p>Staff orientation documentation sighted included necessary components to the role. Caregivers interviewed identified they are paired with a senior caregiver until they demonstrate competency on specific tasks, such as hand hygiene or moving and handling. Staff interviewed reported that the orientation process prepared them well for their role. Staff records reviewed showed consistent documentation of completed staff orientation.</p> <p>The organisation has a documented mandatory annual education and training schedule. Mandatory education includes infection control, restraint/enabler use, moving, and handling. There are systems and processes in place to remind staff of the required mandatory modules and competencies training dates. Interviews confirmed that all staff undertake relevant education per year. Staff education records evidenced the ongoing training and education completed.</p> <p>Twelve of 20 caregivers have completed dementia care education. With eight caregivers enrolled in the required education. This will be completed as per the contractual requirements.</p> <p>Two RNs, including the CNM and one enrolled nurse, were identified as interRAI competent.</p> <p>Staff files reviewed also showed consistent documentation of a 12 month and three-</p>

		monthly performance reviews.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Staffing levels meet contractual requirements. The CNM and an RN are available during weekends and on-call after hours and weekends. Adequate on-site RN cover is provided five days a week. Registered nurses are supported by enough caregivers.</p> <p>There is a documented rationale in place for determining service provider levels and skill mix to provide safe service delivery. Rosters are completed by the CHM and overseen by the CNM. Rosters sighted reflected that staffing levels meet residents' acuity and bed occupancy.</p> <p>Families reported staff provide residents with adequate care. Caregivers reported there is adequate staff available and that they can manage their work.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Agency staff are not currently utilised.</p> <p>At least one staff member on duty has a current first aid certificate, medication competency, and has completed education on dementia level of care as required.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with NP/GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person stamped beside the entry.</p> <p>Archived records are held securely on site and are readily retrievable. They are held for the required period before being destroyed. No personal or private resident information was on display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been</p>	FA	<p>Residents are admitted to Flaxmore Lifecare following assessment from the Needs Assessment and Service Coordination (NASC) Service, as requiring the level of care that Flaxmore Lifecare provides. Prospective residents and their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. All residents are admitted to the facility in accordance</p>

<p>identified.</p>		<p>with current MoH, Covid-19 guidelines.</p> <p>Residents' files reviewed have an activated EPOA in place and a specialist's authorisation for placement. The service is working with the NMDHB and the NASC to resolve a placement authorisation situation for one of the residents.</p> <p>Family members interviewed stated that they were happy with the admission process and the information that had been provided to them. Files reviewed contained the completed demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner. The service uses the DHB 'Yellow Envelope' system to facilitate the transfer of residents to and from acute care settings. There is open communication between all services, the residents, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, is provided for ongoing management of the resident. All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The Medication Management Policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse signs in the medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries with controlled drugs signed in.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of temperature records</p>

		<p>taken at the time of the audit.</p> <p>Good prescribing practices were noted. These included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly NP/GP review was consistently recorded on the medicine chart. There are no standing orders or verbal orders. Vaccines are not stored on site. Residents and staff have received the required Covid-19 vaccines and they have a goal in place to have all residents and staff receiving their vaccine boosters in the first quarter, if applicable.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site with a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician in November 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Nelson City Council (valid until 20th June 2022). At the time of the audit, the kitchen was observed to be clean. The cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan using a paper base recording system.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by families/whānau interviews, satisfaction surveys and in residents' meeting minutes. There are a selection of snacks, fruit, biscuits, and sandwiches for residents 24 hours a day. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	<p>FA</p>	<p>If a referral is received, but the resident does not meet the entry criteria, there are no vacancies, or the referral has been declined from the service due to inappropriate referral from the (NASC) service, there is a process in place to ensure that the prospective</p>

<p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>resident and family are supported to find an appropriate level of care. Examples of this occurring were discussed with the clinical nurse manager.</p> <p>If the needs of the resident change and they are no longer suitable for the services offered a referral for reassessment is made to the NASC service and a new placement is found in consultation with the resident and the whānau/family.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents at Flaxmore Lifecare are assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, cognition and behaviour, nutrition, and activities, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require.</p> <p>Interviews, documentation, and observation verified the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans at Flaxmore Lifecare are paper based. The files reviewed reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the care plans reviewed. A corrective action had been identified by the new clinical nurse manager regarding updating LTCP and ensuring they are all person centred and not generic. This work is currently in progress.</p> <p>All files reviewed had a behaviour management plan in place and de-escalation strategies. Plans were updated as behaviour monitoring documentation determined a review may be required. Each resident also had a "My Life" wheel which offered a quick reference point of the resident's life and significant events.</p> <p>Care plans evidenced service integration with progress notes, activities note, medical and allied health professionals' notations clearly documented, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals, and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The NP interviewed confirmed that medical orders are carried out in a timely manner and staff are proactive at contacting the NP should a resident's condition change, medical orders are followed, and the standard of care for residents was good. Care staff confirmed that care was provided as outlined in the documentation and they have the opportunity for input into care planning.</p> <p>A range of equipment and resources were available and suited to the level of care provided and in accordance with the resident's needs such as pressure relieving devices.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>One full time and one part-time activities assistant provide the activities programme. They are supported by a qualified diversional therapist within the Heritage Lifecare group. Flaxmore are currently recruiting for a qualified diversional therapist. The resident's activity programme is delivered seven days per week 9.30am to 5.30pm.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities, and social requirements. Each resident has a 24-hour activity plan that addresses the resident's needs and previous lifestyle patterns. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated and form part of a six-monthly multidisciplinary care plan review.</p> <p>It is the aim of the activities assistants to get the residents engaging in the community as much as possible. There is a facility van available for drives in accordance with current Covid-19 restrictions. One drive is for residents who are ambulant, and the second drive is for those who are less ambulant.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'Housie', happy hour, movies, BBQs and visiting entertainers prior to the Covid-19 restrictions. There is a lounge area in each of the units, as well as the individual's bedrooms where they can watch their own television or listen to the radio. The monthly Activities Calendar is on display throughout the facility. The YPD resident has specific activities which they enjoy.</p> <p>Residents and families can evaluate the programme through day-to-day discussions with the activities co-ordinator and by completing the resident's next of kin (NOK) satisfaction</p>

		survey and the six monthly multi-disciplinary meeting. Residents' families/whānau interviewed confirmed the programme was interesting and varied.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessment and the multidisciplinary team meeting, or as the resident's needs change. The RN documents evaluations. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans are consistently reviewed for infections, pain, weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the NP/GP sends a referral to seek specialist input. Examples of referrals were discussed with the clinical nurse manager. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as ringing an ambulance if the situation dictates.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies and procedures in place for the management of waste and hazardous substances. The supplier of chemicals has conducted staff training and education on the use of chemicals. Safety data sheets were available and accessible for staff. Staff reported they have received training and education to ensure safe, and appropriate handling of waste and hazardous substances.</p> <p>Protective clothing and equipment appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate,</p>	FA	<p>A current building warrant of fitness is displayed.</p> <p>There is a preventive and reactive maintenance programme in place. Staff are aware of</p>

<p>accessible physical environment and facilities that are fit for their purpose.</p>		<p>the processes of reactive maintenance requests to ensure timely repairs are conducted. This was confirmed at care staff and maintenance staff interviews. The maintenance person is new and confirmed they had received education and orientation on the role.</p> <p>Visual observation evidenced the facility and equipment are maintained to an adequate standard. This was confirmed in documentation reviewed and staff interviews. The testing and tagging of equipment and calibration of biomedical equipment was current.</p> <p>The external areas are safely, maintained and are appropriate to the resident group and setting. Residents are protected from risks associated with being outside. The gardens are well maintained, with additional sensory planting.</p> <p>The facility has a van that is used for residents' outings, and these meet all current legislative requirements.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Bedrooms have a handbasin.</p> <p>There are adequate numbers of toilets and bathrooms of an appropriate design for residents. Separate toilets are available for staff and visitors. The fixtures, fittings, floors, and wall surfaces are constructed from materials that can be easily cleaned. Toilets and showers have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote residents' independence.</p> <p>Hot water temperatures are monitored monthly. When there have been hot water temperatures above the recommended safe temperature, action is taken, and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Residents' bedrooms are personalised to varying degrees. The bedrooms are single occupancy rooms. Bedrooms are large enough to allow staff to move around safely and provide space for residents.</p> <p>Each bedroom door is a different colour and has a visual picture that reflects the personality of the individual resident.</p> <p>There are adequate secure rooms to store mobility aids or other equipment.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is adequate access to lounges, dining areas, and sitting areas/alcoves. Residents were observed moving freely within these areas.</p> <p>Furniture is appropriate to the setting and residents' needs.</p> <p>Communal activities are being run in one of these areas and residents are free to move to alternative areas if they wish.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on-site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow, and handling of soiled linen. Laundry staff demonstrated the process which includes the labelling of residents' personal clothing to ensure their clothes are returned in a timely manner.</p> <p>There is a small, designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Documented systems are in place for essential, emergency, and security services. The fire evacuation scheme for the facility was approved by the New Zealand Fire Services September 2006. The trial fire evacuations are conducted six monthly. The last fire drill was conducted in October 2021. The staff training register evidences all staff have completed first aid training and fire evacuation education.</p> <p>There is emergency lighting, BBQ and gas for cooking, and blankets in case of emergency. Emergency equipment accessibility, storage, and stock availability is to a level appropriate to the service setting requirements. A large emergency water storage tank and separate bottles of water were located on the complex. Documentation was sighted verifying the testing of the tank every six months.</p> <p>The call bell system in place is used by the residents, and/or staff and family to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible, within reach, and are available in resident areas.</p> <p>Staff interviewed confirmed security systems including internal security cameras are in place. Staff and families confirmed an awareness of security processes.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows.</p> <p>Heating is provided by ceiling heaters in residents' rooms and in communal areas.</p> <p>Areas were warm and well ventilated throughout the audit and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Flaxmore Lifecare implements an infection prevention and control programme to minimise the risk of infection to residents, staff, and visitors. A comprehensive and current infection control manual is available to staff and managers. There is evidence that formal reviews of the programme are completed annually.</p> <p>The Clinical Nurse Manager is the designated infection prevention and control co-ordinator/nurse (ICN), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and reviewed at the monthly quality committee meetings. Infection prevention and control matters are also discussed at registered nurse meetings, staff handovers, staff meetings and ultimately at management meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities and confirmed this had been further reinforced since the Covid-19 pandemic emerged with a documented process for each of the alert levels.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN has the appropriate skills, knowledge, and qualifications for the role. Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the NP and the public health unit, as required. The co-ordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>There is a Covid-19 management plan in place which details all the actions required within the facility in response to each of the alert levels. The ICN and the Care Home Manager confirmed the availability of resources to support the programme and any outbreak of an</p>

		infection.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing and clearly documents on each policy the next review date. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are distributed around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and in ongoing education sessions. Education is provided by the IPC Coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, gastro-intestinal, respiratory tract, and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The IPC Coordinator reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at staff meetings and during shift handovers. A good supply of personal protective equipment was available. Flaxmore Lifecare has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	FA	<p>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.</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>The CNM is the restraint coordinator. They provide support and oversight for enabler and restraint management in the facility. The coordinator was familiar with restraint policies and procedures.</p> <p>The facility is restraint free. The register noted the facility has been restraint free for the past three years. The CNM interviewed was unaware when restraint was last used.</p> <p>Restraint is used as a last resort when all alternatives have been explored.</p> <p>This was evident from interviews with staff who are actively involved in the ongoing process of minimisation.</p> <p>Regular training occurs on restraint and enabler use, although enablers would not be utilised in this setting.</p> <p>Review of restraint use is completed and discussed at all quality and staff meetings.</p>
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## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.