

Lexham Gardens Limited - Lexham Gardens Rest Home and Hospital

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:	Lexham Gardens Limited
Premises audited:	Lexham Gardens Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 February 2022 End date: 17 February 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:	42



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

Lexham Gardens Limited (Lexham Gardens) provides rest home and hospital level care for up to 50 residents. The service is operated by New Zealand Aged Care Services Limited and is managed by a care home manager and a clinical leader, with support from a general manager clinical and operations, who oversees the five facilities owned by the organisation. New Zealand Aged Care Services Limited has owned Lexham Gardens since November 2020. The care home is operated under a lease agreement with a landlord owning the building and land.

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

There were no areas requiring improvement.

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


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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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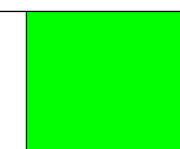
Business and quality plans include the scope, philosophy and objectives with values and the mission statement displayed in the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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 facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen, and equipment were safely stored. Laundry is undertaken both onsite and offsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

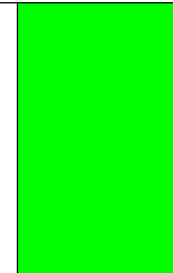
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Two residents were using enablers at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. One resident was using a restraint. A comprehensive assessment, approval and monitoring process with regular reviews was occurring. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	101	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Lexham Gardens Rest Home and Hospital (Lexham Gardens) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent forms as needed.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Resident files had evidence of enduring power of attorney (EPOA), and these had been enacted.</p>

		Staff were observed to gain consent for day-to-day care activities and could appropriately detail how they would respond to refusal of care, medicines or food/fluid.
<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 Advocacy Service were also displayed and available in the facility. Family and staff members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</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 encouraged to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment events in the community.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends, except when otherwise indicated to comply with the Covid-19 National Alert Level in place at the time. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p> <p>Even though there were visitors' restrictions recently due to the pandemic, residents and family members interviewed stated they felt comfortable about the way it was managed and were kept well informed.</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>The care home manager is responsible for the complaints process, with support from the general manager clinical and operations (GM) for more serious complaints. Policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Information is displayed in several places around the facility along with complaint forms.</p> <p>The complaints register reviewed showed that two minor concerns/complaints have been received over the past year and that actions taken, through to an agreed resolution, were documented and promptly resolved. Action plans showed any required follow up and improvements have been made where possible. A complaint received from the Auckland District Health Board was received in January 2021. All related correspondence and an action plan to address findings were reviewed and showed actions were addressed or are in progress. Areas for improvement were also reviewed by the clinical auditor and demonstrated no further concerns in the areas identified.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions</p>

		are required. There have been no complaints received from the Health and Disability Commissioner.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members interviewed 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 during discussion with staff.</p> <p>The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</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>	FA	<p>Residents and families confirmed they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit, when attending to personal cares, by ensuring residents' information is held securely and privately, when exchanging verbal information and in discussions with families.</p> <p>Residents are encouraged to maintain their independence through community activities and regular outings. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during 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>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau. A Māori health plan is in place.</p> <p>Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</p> <p>Family members interviewed reported that staff acknowledged and respected their individual cultural needs. Guidance on tikanga best practice is readily available.</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>Family members interviewed verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed.</p> <p>The resident satisfaction survey confirmed that individual needs are being met.</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 stated that residents were free from any type of discrimination, harassment or exploitation and felt safe.</p> <p>The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Ongoing education is provided on an annual basis which was confirmed in training records sighted.</p> <p>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, abuse or neglect.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<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, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, through the district health board, if needed. Staff</p>

		reported interpreter services were rarely required due to all present residents being able to speak English and/or te reo Māori.
<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>The business plan for Lexham Gardens was developed following purchase of the facility in November 2020 and has recently been reviewed. Opportunities for development and actions have been identified. The philosophy is defined, as is the scope of service. Values and the mission are well displayed in the facility. A sample of four monthly reports to the board showed adequate information to monitor performance was reported including financial performance, emerging risks and issues, COVID-19 updates and any section 31 reports. The GM was clear about the direction and priorities for the service.</p> <p>The service is managed by a care home manager (CHM) who holds relevant qualifications and has been in the role for around one year. The clinical management is overseen by a clinical leader (CL) who is also experienced in aged care. Responsibilities and accountabilities are defined in a job descriptions and individual employment agreements. During the time of the audit, the GM, who normally oversees the five facilities owned by New Zealand Aged Care Services Limited, was based at Lexham Gardens as both the CHM and CL were also working as registered nurses (RNs) to fill in roster shortfalls due to RN vacancies that have been hard to recruit to. The GM previously managed Lexham Gardens and is familiar with systems and processes.</p> <p>The service holds contracts with the DHB for aged related residential care (ARRC) - hospital and rest home level care and with the MoH for younger people with a disability (YPD). There were 21 hospital care residents and 20 rest home care residents at the time of audit. There was also one resident receiving respite care (hospital level). Two of the hospital care residents were on ACC contracts. Three residents were under the age of 65 years (one rest home and two hospital).</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>When the CHM is absent, the CL will normally fill in with support from the GM as needed. On occasions, relief roles/staff can be sourced from the other four facilities owned by New Zealand Aged Care Services Limited. The management team reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk</p>	FA	<p>The organisation has a quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular</p>

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>patient satisfaction survey, monitoring of outcomes, and clinical incidents including infections and pressure injuries. Staff meetings act as the forum for discussion of quality and risk components. Meeting minutes reviewed provided evidence of reporting and discussion with areas for improvement identified. Data was reviewed and compared with previous months. The GM reported that benchmarking with the other facilities within the group is in the development phase. Staff reported their involvement in quality and risk management activities through audit activities and attending staff meetings.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed residents were either satisfied or very satisfied with care. There were no areas of dissatisfaction identified. A food specific survey was also completed in August 2021, again with no areas of concern noted. There is also a residents' meeting, chaired by the activities coordinator. Minutes reviewed showed discussion on activities and food services with suggestions made followed through.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements. Policies were current and reviewed two yearly, unless there was a need to review earlier.</p> <p>The CHM is familiar with health and safety requirements. Health and safety hazards have been identified and were documented on a hazard register and displayed in the specific areas (eg, laundry). A range of health and safety policies were available.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed (seven) showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to staff at meetings, and to the board.</p> <p>The GM and CHM described essential notification reporting requirements, including for pressure injuries. They advised there have been notifications made for a missing resident (notified to and found by the police) and for the appointment of the CL in June 2021. There have been no coroners' inquests.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p>

<p>practice and meet the requirements of legislation.</p>		<p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after three-months and then annually.</p> <p>Continuing education is planned annually, including mandatory training requirements. Several care staff (HCAs) have either completed or part completed a New Zealand Qualification Authority education programme. At the time of audit, the programme was on hold with plans to restart this later in the year. Competencies are regularly assessed for a wide range of skills to meet the requirements of the provider's agreement with the DHB. There was a wide array of training opportunities provided with each evaluated and a report documented. Both the CL and CHM are maintaining their competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents, as described by the CL and CHM. An afterhours on call roster is in place, with staff reporting good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them, although at times they were busy. They reported working as a team. Residents and family interviewed supported this.</p> <p>Over the past year, there was a significant reduction in occupancy. The occupancy is now increasing, and two health care assistants (HCAs) are being recruited to manage the increase. Observations and review of a four-week roster cycle confirmed adequate HCA cover had been provided, with staff replaced in any unplanned absence. The roster for the week following the audit, where there was to be an increase in resident numbers, showed an increase in HCA hours on the morning and afternoon shifts. A casual pool of HCAs has not been used recently due to the risks imposed from COVID-19.</p> <p>At the time of audit, the CL and CHM have been working rostered shifts of varying lengths, from eight to 12 hours. The current four RNs available have been able to cover the shifts with the support of the GM who is now based at Lexham Gardens, and by using a flexible approach. Health care assistants reported that the RNs are available for support and advice when needed. The GM described a range of strategies being explored to address the RN shortage, with an overseas recruitment pending and additional RN support to cover non-clinical aspects of the role.</p> <p>Two staff members on duty have a current first aid certificate and there is 24/7 RN coverage in the</p>

		hospital. There is also a cook and kitchen hands, laundry staff, a maintenance person (20 hours a week) and household staff rostered.
<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>The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographics, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment entered into the momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a catalogue system. Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission.</p> <p>Files reviewed contained completed demographic detail, assessments, EPOA had signed admission agreements and consented for admission. Service charges comply with 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>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. Family members interviewed reported being kept well informed during the transfer of their relative.</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 days 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. Regular medication audits are completed and are followed with appropriate corrective actions. There was evidence of pharmacy involvement. There was one rest home resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates.</p> <p>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.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Vaccines are not stored on site.</p> <p>Good prescribing practices noted 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 GP review was consistently recorded on the medicine chart. Standing orders are not used.</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 by experienced cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in July 2020.</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 Ministry of Primary Industries expires on 21 July 2022. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have completed safe food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary</p>

		<p>profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food, snack foods, and fluids to meet their nutritional needs. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the GP and whānau/family. Examples of this occurring were discussed with the nurse leader and office administrator.</p> <p>There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents are assessed to develop an initial care plan. Within three weeks of admission a comprehensive assessment is completed using nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and interRAI, as a means to identify any deficits and to inform long term care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by a trained interRAI assessor on site.</p> <p>Files audited had evidence of wound management, such as a wound care plan and evaluation. Evidence of wound management, including photographs of chronic wounds, was sighted. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p>

<p>promote continuity of service delivery.</p>		<p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Family members reported participation in the development and ongoing evaluation of care plans.</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>Documents, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by a diversional therapist (DT) with the support of care staff. A wide range of activities are provided seven days a week.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review. Social history including past likes and important past events was completed during the admission. An activities plan was completed by the DT and was reviewed as part of the six-monthly care plan review.</p> <p>The monthly activities planner sighted matches the skills, likes, dislikes and interests identified in the assessments. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through care plan reviews and satisfaction surveys. Family members interviewed confirmed the residents enjoy the programme. Residents were observed actively participating in the planned activities occurring during audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the</p>

		<p>service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted.</p> <p>When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. The service has a contracted GP who does weekly visits or virtual consultations during the pandemic. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. All referrals are followed up by the GP or RN. The family/whānau are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. A weekly rubbish collection meets the needs of the service.</p> <p>There is provision and availability of protective clothing and equipment (PPE) and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building systems status report (in lieu of a warrant of fitness – due to COVID-19 restrictions) was displayed.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance person and CL and from observation of the environment. The environment was hazard free and resident safety was promoted. Personalised equipment is</p>

		<p>available for the younger residents and those under an ACC contract.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 15 ensembles and additional facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Most bedrooms provide single accommodation with four rooms able to accommodate two residents or form a larger area in the case of one current resident. Where rooms are shared, approval is sought. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>	FA	<p>Communal areas are available for residents to engage in activities. The several dining and lounge areas of various sizes enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry</p>	FA	<p>Laundrying of large items is undertaken off site with a small laundry on site for residents' personal clothing/items. Care staff have dedicated hours in the laundry and the HCA/laundry person spoken</p>

<p>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>with demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. The cleaning person interviewed was familiar with chemicals in use and cleaning processes. Training has been undertaken, as confirmed in training records reviewed. Cleaning equipment is colour coded. 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. The facility was observed to be clean and tidy.</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>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. There is an infection control outbreak plan with plentiful PPE supplies available. The current fire evacuation plan was approved by the New Zealand Fire Service on the 27 March 2000. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service. A record of fire training attendance is held. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet The National Emergency Management Agency recommendations for the region. There is an increased supply (two weeks supply) at the time of audit, in case of specific pandemic requirements. A generator is on site and tested regularly. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation,</p>	<p>FA</p>	<p>Residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Many have doors that open onto the outside internal courtyard area. Heating is provided by a central heating system, which can be adjusted as needed. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. There is a designated external smoking</p>

and an environment that is maintained at a safe and comfortable temperature.		area for those residents who smoke.
<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>Lexham Gardens implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.</p> <p>An RN is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager. Infection control data is discussed during the staff meetings and a copy of the minutes are available for staff. This infection control committee includes the RN, health care assistant, clinical leader and care home manager.</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. Due to the COVID-19 pandemic, all visitors are requested to log their visit by entering their details on a paper log or by scanning a Ministry of Health bar code. 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.</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 IPC coordinator has appropriate skills, knowledge and qualifications for the role. The RN has attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There have been no infectious disease outbreaks reported in the facility since the last audit.</p>
<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</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are reviewed annually and included appropriate referencing.</p> <p>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. Hand washing and sanitiser dispensers are readily available around the facility.</p>

<p>and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>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>	<p>FA</p>	<p>Interview, observation and documentation verified staff have received education in infection prevention and control at orientation and 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.</p> <p>When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. In response to the recent pandemic, staff have completed training on the COVID-19 pandemic, hand hygiene, isolation precautions and use of personal protective equipment.</p> <p>Residents are encouraged and reminded about handwashing and increasing oral fluids during hot weather.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. 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 via regular staff meetings and at staff handovers. Graphs are produced that identify trends, and comparisons against previous months and this is reported to the clinical manager and staff. The monthly infection rates remain low. There was evidence of staff education on 'chain of infection transmission' following an increase in number of infections.</p> <p>A COVID-19 pandemic preparedness document was sighted and staff interviewed were aware of this plan.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of</p>	<p>FA</p>	<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. The designated</p>

<p>restraint is actively minimised.</p>		<p>restraint coordinator is one of the registered nurses; however, was not available for interview during the audit. The CHM was interviewed and was familiar with processes and demonstrated a sound understanding of the organisation's policies, procedures and practice.</p> <p>On the day of audit, one resident was using a restraint (bedrail). Two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint committee minutes, the file reviewed, and from interviews with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint committee, made up of the restraint coordinator, an HCA, domestic and maintenance staff, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of the restraint committee meeting minutes, review of the file of the one resident using restraint, review of the restraint register and interviews with the CHM that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraint is being monitored and analysed.</p> <p>Evidence of family/EPOA involvement in the decision making was on file for the resident using the restraint. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN/restraint coordinator undertakes an initial assessment of the need for restraint with involvement of the team and the resident's family/whānau/EPOA. The CHM described the documented process. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified all necessary requirements relevant to the person. A trial without the restraint was attempted for the current resident which was not successful. The restraint was recommenced to ensure the resident's safety and security. Completed assessments were sighted in the record.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised. The CHM described how alternatives to restraints are discussed with staff and family members (e.g. the use of sensor mats and low beds).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and</p>

		<p>all processes ensure dignity and privacy are respected.</p> <p>A restraint register was maintained, updated every month and reviewed at each restraint committee meeting. The register was reviewed and contained the residents currently using a restraint and enablers.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of the one resident's file showed that the use of restraint was reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint committee meetings. There was evidence of family involvement in the evaluation process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the staff meetings. Minutes of meetings reviewed confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the doctor, staff and families. A six-monthly internal audit also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the CHM confirmed that the use of restraint has reduced from eight to one over the past year.</p>

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

No data to display

End of the report.