

Masonic Care Limited - Glenwood Masonic Hospital

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by 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:	Masonic Care Limited
Premises audited:	Glenwood Masonic Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 31 July 2017 End date: 31 July 2017
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:	44

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

Glenwood Masonic Hospital provides residential care for up to 54 residents who require rest home and hospital level care. On the day of audit 44 beds were occupied. The service is managed by a facility manager and an acting clinical nurse leader. Residents and families interviewed spoke positively about the care provided.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a nurse practitioner.


The previous requirement relating to initial assessments and care plans not being developed within the required timeframes has been addressed. There are no areas that requires improvement from 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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Information regarding residents' rights, access to interpreter services and how to lodge a complaint is available to residents and their families. The complaints register is current and all complaints have been entered. Residents and their families reported their satisfaction with the open communication with staff.

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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Masonic Care Limited is the governing body and is responsible for the service provided. A strategic business plan and quality and risk management systems are fully implemented and documented scope, direction, goals, values, and a mission statement were reviewed. Systems are in place for monitoring the service provided including regular reporting by the facility manager to the chief executive officer.

The facility is managed by an experienced and suitably qualified facility manager. The facility manager is a registered nurse and is supported by an acting clinical nurse leader/registered nurse. The clinical nurse leader is responsible for oversight of the clinical service.

Quality improvement data is collected, collated, analysed to identify trends and reported back to staff. There is an internal audit programme in place and internal audits have been completed. Corrective action plans have been developed to address areas identified as requiring improvement. Risks have been identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

Policies and procedures on human resources management are followed. Current annual practising certificates for health professionals who require them were on file. An in-service education programme for staff via on-line learning and other training sessions is provided. Staff are also encouraged to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The facility manager and acting clinical nurse leader are rostered on call after hours.

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' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff, a designated general practitioner and a nurse practitioner. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses, enrolled nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food control plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. 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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Building and plant complies with legislation. A current building warrant of fitness is displayed. There have been no alterations to the building since the previous audit.

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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Policies and procedures for restraint minimisation and safe practice are in place. There are currently residents safely using restraints and enablers.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked 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	14	0	0	0	0	0
Criteria	0	38	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The facility manager (FM) is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that included 14 complaints since the previous audit. These were managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code) . Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and/or displayed. Review of quality and staff meeting minutes provided evidence of reporting of any complaints to staff. Care staff confirmed this information is reported to them via the staff meetings.</p> <p>The FM advised there have been no investigations by outside agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Residents' files demonstrated evidence of open disclosure and effective communication with residents and families. Communication was documented in family communication sheets, on the accident/incident forms and in the residents' progress notes. Evidence was signed of resident and family input into the care planning process. Family members stated they were informed in a timely manner about any changes to the resident's status. A quarterly newsletter is also provided to residents and families that keep them up to date with news at Glenwood</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>Hospital.</p> <p>The facility manager advised there is a list of interpreters at the facility. Interpreter services can also be accessed from the local DHB when required.</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>	<p>FA</p>	<p>Masonic Care Limited is governed by a board of trustees who meet 11 times throughout the year. A strategic business plan for the group includes a scope, direction, goals of the organisation, values, and a mission statement as well as the monitoring and reporting processes against these systems. Glenwood Hospital has a business plan with specific goals. The groups facility managers meet quarterly with the CEO and a wide range of topics are discussed.</p> <p>The service philosophy and mission statement are in an understandable form and are available to residents and their family / representative and other services involved in referring people to the service.</p> <p>The facility manager and CEO discuss the service at least weekly and meet on site regularly. The FM confirmed this.</p> <p>The facility manager, who is a registered nurse, has extensive experience in the aged care sector and has been in this position since June 2015. The facility manager is supported by an acting clinical nurse leader who is a registered nurse and was appointed to their current position in October 2016. Prior to this appointment the acting clinical nurse leader (ACNL) was a RN on the floor at Glenwood Hospital. The ACNL is responsible for oversight of clinical care. Interview of the FM and ACNL and review of their personal files evidenced they have undertaken on-going education in relevant areas.</p> <p>The care planning policy includes the requirement for interRAI assessments. Seven of the nine RNs are interRAI trained.</p> <p>Glenwood Hospital is certified to provide hospital and rest home level care. There were 25 hospital level care residents and 18 rest home level care residents. This includes six residents under the 'Occupational Right Agreement' (ORA) and three residents under the age of 65 years.</p> <p>The service has contracts with the DHB to provide Aged Related Residential Care, 'Health Recovery Programme', 'Long Term Support – Chronic Health Conditions' 'Residential Care for Palliative Care Patients' and 'Respite Services'. Contracts are also held with the Ministry of Health and ACC for the three residents under the age of 65 years.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>A risk management plan is used to guide the quality programme. Purpose, goals and objectives and scope are included in the plan.</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>The resident satisfaction survey was completed in 2017 and results indicated that residents and families were satisfied to very satisfied with the services provided.</p> <p>Completed audits for 2017, clinical indicators and quality improvement data was recorded on various registers and forms. Review of the quality improvement data provided evidence the data was being collected, collated, and analysed to identify trends and corrective actions are developed, implemented and evaluated. Quality data is benchmarked including graphs, by an external agency and within the group.</p> <p>Management, quality (including infection control, health and safety and restraint), staff and RN/EN meetings are held monthly and minutes were reviewed. The FM and quality coordinator stated quality data is discussed at the various meetings. There was documented evidence of reporting on various clinical indicators and quality and risk issues in these meetings. Staff reported that copies of meeting minutes and graphs are available for them to review in the handover room. This was confirmed by observations during the audit.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are reviewed and were current. Staff confirmed they are advised of updated policies and that the policies and procedures provided appropriate guidance for the service delivery.</p> <p>A health and safety manual is available. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk.</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 are documenting adverse, unplanned or untoward events on an accident/incident form. The ACNL and FM review these and the quality coordinator is responsible for inputting the data electronically.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>The FM stated they are aware of essential notification reporting to external agencies. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM reported there have been essential notifications made to the Ministry of Health since the previous audit.</p>

<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>	<p>FA</p>	<p>There are policies and procedures on human resources management. Annual practising certificates for all health professionals who require them were current. The skills and knowledge required for each position was documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed along with employment agreements, confidentiality statements, professional boundaries guidelines and acceptable behaviour in the workforce. Individual records of education were maintained for each staff member and were reviewed. Staff files evidenced reference checking and police vetting have been undertaken prior to employment.</p> <p>The community and education coordinator is responsible for oversight of the in-service education programme. The education programmes for 2017 was reviewed and evidenced education is provided via online training either on site in a group setting or after hours. Other training sessions not covered on-line are provided, as well as external education. The local DHB also provides opportunities for RNs to attend on-going education. Staff responsible for medication management have current medication competencies and clinical staff have current restraint competencies.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme. An enrolled nurse is the assessor for the programme.</p> <p>An orientation/induction programme is available and all new staff are required to complete this within two months of employment. Staff performance is reviewed at the end of the orientation, goals are set and a performance appraisal is completed annually thereafter. Orientation for staff covers the essential components of the service provided. Staff confirmed they have completed an orientation. Care staff also confirmed their attendance at on-going in-service education and that their performance appraisals are current.</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 was 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. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. 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</p>

		<p>recommended range.</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 is consistently recorded on the medicine chart.</p> <p>There were four residents who self-administer medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the Acting Clinical Nurse Leader (ACNL) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are used, were current and complied with guidelines.</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>	FA	<p>The food service is provided on site by a cook and a kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</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 control plan and registration issued by the Masterton City Council (exp. 31-03-2018). Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary 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.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews. Resident satisfaction surveys and resident meeting minutes note ongoing concerns in regard to the desired needs of individual residents; evidence verified these are continually being addressed.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.6: Service</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>needs was evident in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was 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 trained diversional therapist, with support from a recreation assistant.</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 residents needs change and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated dissatisfaction with the programme only being offered five days a week. This feedback has been addressed, with the programme now operating seven days a week. Feedback from meetings is also used to improve the range of activities offered. Residents interviewed confirmed they find the programme interesting and it addresses their needs.</p> <p>Activities for younger residents focus around assisting them to access interest groups in the community, and evidence verified the needs of the younger residents are being addressed.</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. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were consistently reviewed 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 dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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 warrant of fitness is displayed that expires on the 27 August 2018. There have been no structural alterations undertaken since the previous audit.</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, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastrointestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this including the management of the infection is documented in the residents' clinical records and on an infection reporting form. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The infection control nurse reviews all reported infections. Monthly surveillance data is collated, recorded in the electronic resident management system and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality meetings, staff meetings and at resident handovers as confirmed in meeting minutes sighted and interviews with staff.</p> <p>Data is benchmarked internally within the group and externally by an external provider. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Documented systems are in place to ensure the use of restraint is actively minimised. There were eight residents using restraint and three residents using an enabler during the audit. The restraint coordinator is the ACNL. In-service education relating to restraint and challenging behaviour has been provided to all staff. Restraint usage is an agenda item for the management, quality, staff and RN/ EN meetings. Staff demonstrated good knowledge of restraint and enabler processes. Residents' files evidenced completed documentation relating to restraint and enabler use.</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.