

## Case management and audit: Operational procedures

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**This document sets out the ‘cornerstone’ processes associated with clinical case management at the Centre. It should be read in association with other policy and procedures as indicated, which may give more detail on particular issues.**

**Central to our work with clients is a commitment to ensure that all services comply with the Code of Health and Disability Service Consumers’ Right (1996).**

### Purpose:

1. To ensure the consistent management of cases across time, and given the diverse level of both skill and experience between qualified staff, interns, and students.
2. To develop standard clinical management practices that are amenable to clinical review.
3. To detail the parameters and process of clinical review.

### Procedures:

## REFERRALS

### Associated documents

- TPC Manual.
- Client management for ‘Health Waikato’ interns.
- Referral receipt and processing.

1. When a community or self-referral is received at TPC it should be dated (by the person who receives the referral), or the date highlighted, so that receipt date is clear (this is the date entered in the *Primhd* system as ‘Referral Start Date’). If further information about the referral is required in order for it to be considered it should be passed to one of the Centre’s clinical staff who will follow-up the referral. When all the required information has been obtained the referral should then be presented at the next scheduled clinical staff meeting.
2. Details of telephone referrals should be recorded on the Centre’s Generic Referral Form (available on the intranet).

3. **Community referrals can only be formally accepted at the weekly meeting of the Centre's clinical staff.** This is to assist in the management of workloads and ensure that referrals accepted are consistent with the purposes of the Trust. Therefore, those making enquiries **CANNOT** be promised a service prior to presentation at this meeting. **All referrals must be presented at this meeting.**
4. Referrals to interns working with the Health Waikato (HW) MHTs must be managed in accordance with the prevailing protocols and procedures. These leave any decision regarding acceptance of specific referrals to the intern's supervisor and the HW mentor. However, all these referrals must also be presented at the Centre's clinical team meeting so that staff know who is 'in the system'.



**Audit point 1** – *Was the referral presented at the clinical staff meeting?*

5. After a referral has been considered by the clinical staff meeting, whatever the outcome (accepted/declined), the relevant details **must** be entered into the **Referral Book**. To this end **all** referrals must be returned to the Administrator for processing.



**Audit point 2** – *Have relevant client details been entered into the Referral Book (including the date when the referral was received)?*

6. When a community referral is **accepted**, the referral details are passed Administrator who will,
  - a) Enter client details into the Referral Book,
  - b) Make up a file,
  - c) Register the client on the Centre's database (PPS),
  - d) Sent the appropriate standard letters to the client and the referrer. This includes communicating an estimate of waiting time if clients are placed on the waiting list. This estimate should be given to the Administrator by the clinical staff member who presented the referral.
7. Copies of all correspondence regarding a client must be kept in the case file.
8. Administration for HW referrals to HW interns is to be dealt with according to the prevailing TPC-HW protocol that is available on the intranet. The Centre's Administrator will make-up client files, but **the intern is responsible for**,
  - a) Entering the client's details into the Referral Book,
  - b) Entering the client onto the Centre's database, and
  - c) Generating any letters or other required documentation.
9. When a referral is **declined** a clear reason for this must be made in the minutes of the clinical staff meeting at which the referral was presented. Also, it is the responsibility of the staff member who took the referral (self-referrals), or the

Director (agency referrals), to contact the client/referrer and explain the reason that the referral has been declined.



**Audit point 3** – *Have relevant administrative tasks related to accepting/declining the referral been completed?*

10. When a client is declined every effort should be made to identify alternative services where they may obtain assistance. This may include making contact with their General Practitioner.
11. The primary criteria regarding the acceptance of community referrals is that they should be of a complexity appropriate for assessment and treatment offered by a 2<sup>nd</sup> Year or Intern Psychologist within the duration of their placement. This generally excludes,
  - a) those experiencing chronic (mental) health problems
  - b) those with multiple complex problems
  - c) referrals which do not have a primarily health focus unless students/interns are able to develop important psychological skills that could not be learned in other ways, e.g., the use of specific psychological assessment
  - d) clients where there is likely to be ongoing legal proceedings, e.g., clients involved with the Family Court.
  - e) Clients who are not willing to accept the Centre's training or video supervision requirements.

Interns funded by Health Waikato's Adult Mental Health Service will work almost exclusively with clients referred from that service.

Qualified clinical staff generally accept referral made under specific service contracts, or with clients who have previously been seen by students or interns at the Centre.

There are no exclusion criteria based on age, ethnicity, or cultural considerations.

We do not offer prioritisation to some problem presentations or client types. We are not a Crisis Response Service.

## CULTURAL ISSUES

12. Caseworkers need to be alert to any issues associated with either a cultural difference between themselves and their client, or where the expression of cultural preferences and values requires a change to a practitioner's usual practice. **Such issues must be documented carefully and raised in supervision.** NB. 'Culture' refers to those patterns of thinking/behaviour, traits, and products that are an expression of a particular community or population.

13. Clients must be given the opportunity and support to engage in culturally relevant processes and protocols when it does not compromise the efficacy of the assessment/intervention being undertaken with them, and does not compromise the well-being of others.

## INITIAL CONTACT

14. When a client is allocated to a caseworker the client should be contacted as soon as possible (within three working days) in order to arrange an initial appointment.
15. When an appointment is offered by letter the caseworker should also,
- confirm their designation (if they are a student or intern they must also name their supervisor),
  - remind the client that sessions may be videotaped (and will certainly be videotaped if the caseworker is a student or intern),
  - confirm the fees that will be charged (if any),
  - include a copy of the Centre's *Client Information* sheet.
16. When an appointment is made by telephone points a) – c) above should be discussed during the telephone conversation. When time allows a letter confirming the appointment, enclosing the *Client Information* sheet, should be sent.



**Audit Point 4** – *If an appointment/confirmation letter has been sent, does it cover all the points raised in paragraph 15?*

## CONSENT

### Associated documents

- TPC Manual
- Consent forms
- Client management for 'Health Waikato' interns.

17. When the client arrives for an initial assessment appointment, confirm that he/she has received a copy of the Centre's *Client Information* sheet. If not this should be given to the client.
18. Give the client the opportunity to read the generic consent form. Answer any questions that the client may have. Invite the client to sign the relevant sections of the consent form. Provide a photocopy of the completed consent form to the client; file the original in the case file.

### **Video consent**

This is **required** from clients who are working with interns and 2<sup>nd</sup> year students. Because students are unregistered and interns are registered under a limited scope of practice, the primary responsibility for their works rests with their clinical supervisor. Videotaping sessions assists with the supervision process. The decision to dispense with videotaping a session is one that **only the supervisor** can make.

*What if the client doesn't want to sign the consent?* Consult your supervisor immediately. It may be that interns/students will not be permitted to continue with a session if it cannot be videotaped.

### **Consent to access information**

This is required if specific information is to be sought from a person/agency who is not involved in providing ongoing health care to the client. Consent is obtained for an approach to be made to a **specific person** for a **specific reason** within a **specified timeframe**.

*What if the client doesn't want to sign the consent?* Inform your supervisor. Discuss with the client the limitations that this may impose on your ability to work with them.

### **Consent for inter-agency liaison**

This consent allows the caseworker to consult with non-health agencies who are providing services directly related to those being provided at the Centre. While consent is usually obtained for liaison with healthcare providers this is not required. However, the client must always be informed that such liaison is taking place.

*What if the client doesn't want to sign the consent?* Inform your supervisor. Discuss with the client the limitations that this may impose on your ability to work with them.



**Audit Point 5** – *Have appropriate consents been obtained?*

## DOCUMENTATION

### Associated documents

- TPC Manual
- “Psychology Centre guidelines for case notes”, available on the intranet.
- Client management for ‘Health Waikato’ interns.

19. When the client has been referred to TPC by a third-party, and with the client’s knowledge, the referrer should be informed of the commencement of the assessment (at the time the appointment is confirmed), at completion of the

assessment/start of treatment (with a summary report and treatment plan as appropriate), and at the end of any intervention (with a summary report as appropriate). In addition, the referrer should be updated during the course of the intervention on a regular basis or when significant events occur.

20. Clients should be consulted regarding the type and amount of information that they are willing to be communicated to their referrer, or other parties, e.g., other health practitioners with whom they are consulting.



**Audit Point 6** – *Have the required letters been sent to the appropriate people at the time of the first appointment, at the end of the assessment, and at discharge?*

21. **Case notes must be kept on all sessions.** Guidelines for completion of case notes are available on the Centre’s intranet. Case notes may be typed or handwritten (legibly). Be aware that clinical notes are also a legal record of the session. You may occasionally need to alter the way you take notes to ensure that all relevant information is included. Notes should be filed in chronological order in the case file – front to back.
22. At all times staff/students/interns must be explicit in their designation. For students/interns this is as a clinical psychologist in training. This clarity is also required when preparing and signing clinical documents. Interns must identify themselves as “Intern Psychologists”, and 2<sup>nd</sup> Year students as “Clinical Psychology Students”.
23. Case notes should be completed within 24 hours of the completion of the session. Under normal circumstances the caseworker should allocate time immediately after a session in which they can write the case notes.
24. When safety or ethical issues are raised during a session they should be recorded with care, indicating the circumstances under which the issue has arisen, the content of the discussion, and the actions that are being taken. **These notes must be written and filed at the earliest opportunity.** For students/interns these notes **must** be countersigned by their supervisor. If the supervisor is not available then they can be signed by another member of staff, but must be presented to the supervisor at the earliest opportunity.

If staff/students are in any doubt about how to respond to an issue of safety or ethics being raised they **must** consult with their supervisor or another qualified staff member immediately. This may necessitate suspending the clinical session while supervision is sought.

25. A record of all contacts with the client should be kept on the **Contact Sheet** at the front of the case file. This includes a record of cancelled and failed appointments, telephone conversations (including a case note if required). Details of these contacts should also be added to the Centre’s database (currently *PPS*).



**Audit Point 7** – *Are all case notes, a) legible? b) signed/designated/dated? c) complete (plan/content/outcome)? d) countersigned (if applicable)?*



**Audit Point 8** – *Is the contact sheet up to date? Does it tally with the case notes in the file and entries on the TPC database?*



**Audit Point 9** – *Has the client been entered onto the TPC database (including at least - name, address, contact phone, date of birth, ethnicity, referral source, GP contact)?*

26. An additional protocol exists covering liaison and transfer of information to HW's Adult Mental Health Service for staff/students who are working with clients referred under the Heads of Agreement between TPC and HW, and where there are currently other HW Mental Health staff working with the client.
27. For general referrals, i.e., where an alternative assessment structure and timeframe is **not** specified under the terms of a separate contract, assessment reports should be completed after the second assessment session, although this can be in draft form. A copy of the draft report must be included in the client's case file and clearly marked as a "DRAFT". Complete/confirmed reports should be on the client's file after the fourth session. The clinical supervisor must countersign clinical assessments conducted by interns/students. Guidelines for compiling psychological reports are contained in the TPC Manual, examples of report formats are also available.



**Audit Point 10** – *Has an assessment report been filled at the appropriate time? For students/interns - if a confirmed report is on file has it been countersigned by the supervisor?*

28. The Centre uses the Outcome Questionnaire 45.2 (OQ 45.2) with all adult clients to provide a measurement of psychological distress at the point on intake and discharge (at least), and to monitor change during the course of any intervention. The use of additional measures should also be considered. Copies of completed OQ45's must be placed in the client's file, and a photocopy placed in the Director's pigeonhole.



**Audit Point 11** – *Has the OQ45 been used?*

29. Under normal circumstances, when it is not likely to compromise the well-being of the client, copies of any letters and reports which are about the client should be discussed with him/her before they are disseminated. The client should be given copies of these documents if they are requested. A decision to withhold documentation from a client should be discussed with the clinical supervisor before being actioned. The reason for withholding documentation should be noted in the clinical file.



**Audit Point 12** – *Is there clear indication which letters/reports have been copied to the client/referrer? If copies have not been supplied to the client there should be a documented reason for this.*

## FAILURE TO ATTEND APPOINTMENTS

30. When a client fails to attend an appointment for whatever reason this should be recorded in the case file and PPS. Appointments are deemed to have been **cancelled** if the appointment is cancelled/postponed by the client with more than 24 hours notice. The failure to attend is recorded as **‘Did not attend’ (DNA)** if the client cancelled/postponed with less than 24 hours notice, or simply did not attend the appointment.
31. There is currently no charge for fee-paying clients when they cancel or DNA an appointment.
32. Every effort should be made to understand the reasons why a client may fail to attend their appointment, and explore this in sessions. However, if a client DNAs **two appointments** in succession without making any contact with the Centre, or responding to the caseworker’s enquiries, they should be sent a letter informing them that they are being discharged.



**Audit Point 13** – *Are cancellations and DNAs recorded on the contact sheet and the Centre’s database?*

## REQUESTS FOR INFORMATION FROM THE CLIENT OR THIRD-PARTIES

### Associated documents

- TPC Manual
- Information release policy

33. Health information about an individual client belongs to the client; the file in which it is recorded belongs to The Psychology Centre. Clients have no right to

- take possession of a file belonging to the Centre, although arrangements can usually be made for them to review and have copies of the information in the file. Clients have an absolute right to know what information is kept in their file except where,
- a) the information may compromise their safety, or the safety of another person, and
  - b) the confidential health information of another person may be divulged.
34. Requests to access health information about a client should usually be in writing, even if the request is from a client about information stored in their own case file.
35. All requests for information about a client should be discussed with to the Director, who is the Centre's designated Privacy & Information Officer.
36. All requests for information will be handled in accordance with the Health Information Privacy Code and other pertinent legislation.

**Request from a client.**

37. No justification of the request is required. It is only under exceptional circumstances that such a request would/could be declined. However, there may be some delay in preparing the file for the client to review.
38. The Centre cannot be responsible for the content of documentation authored by those outside the Centre. For this reason advice should be sought from the original author, or their agent, regarding such documents. Where advice cannot be obtained caution should be exercised regarding the release of this information.
39. When clients have access to their files it may be necessary for their caseworker to sit with them in order to assist with interpreting the information. A charge can be made for this that is consistent with the Centre's policy on fees. After the client has seen the contents of their file copies of requested documents can be made at the client's request. Once again, a charge can be made for this photocopying if necessary, i.e., a large number of pages are required. Staff should consult their supervisor or the Director regarding any charges that are being considered.
40. Clients have the right to request the correction of information held about them when it is factually incorrect. As this requires alteration of a legal document any changes should be signed and dated, giving a brief explanation of why the change has been made, e.g., "incorrect information changed at the request of the client".
41. **All** copies of documents containing errors must be corrected, including documents that have been sent outside the Centre. This is why it is important to record where reports/letters are sent. Notice of any corrections and/or revised documents must be sent to all those who received the original document.

## Requests from a third party.

*When the third party is a parent/guardian of a client who is under 16 years of age.*

42. A person under the age of 16 years has the same right to privacy under the Privacy Act and the Health Information Privacy Code as those over the age of 16 years. However, as parents/guardians are legally responsible for their child(ren) under this age, and may not be fully able to discharge this responsibility without full information, extra care must be taken in deciding what information can/should be released to parents/guardians with respect to young children. The following actions must be taken,
- a) Consult with supervisor and Director
  - b) Inform the client of your intention to release information (negotiate with the client exactly what information they are happy for you to release, explain why other information is being released if this is the case, negotiate how the information will be released).

*Other third party requests.*

43. When information is requested by a third party, and where there is no legal obligation to divulge the information, the third party is required to provide a signed release form from the client specifying the information that can be passed on. This form **must** be placed in the client's file, and a note made regarding the date and exact nature of the information which was released.



**Audit Point 14** – *If information has been released to the client or a third party – have the appropriate request/consent forms placed on the file? Has the exact nature of the disclosed information been specified?*

## FEES

### Associated documents

- TPC Manual
- Fees policy
- Current 'Referrers Newsletter', available from our Administrator.

44. The charging of fees, including the process of negotiating fees, is covered in a separate protocol and within the Centre's Manual. Both these documents are available on the Centre's intranet. Any change to the standard fee must be discussed with the supervisor/Director.
45. Information regarding the prevailing fee structure is available on the Centre's Internet site ([www.tpc.org.nz](http://www.tpc.org.nz)), on the current version of the referrer's newsletter (available from our Administrator), or in the reception area.

46. Our policy is to allow clients to continue receiving services if they have up to two unpaid session fees outstanding. After this sessions can only continue to be provided with the approval of the supervisor (for students and interns), or the Director.
47. Clients referred by HW to HW-funded interns under the Heads of Agreement are not charged a fee for their consultations.
48. Client consultations undertaken under some existing service contracts have specific fee schedules that must be applied.



**Audit Point 15** – *Arrangements are in place to collect appropriate fees from/for clients. Fee payment is documented and receipts issued as appropriate.*

## COMPLAINTS

### Associated documents

- TPC Manual
- Complaints policy

49. The Psychology Centre has procedures in place for reporting and processing customer complaints. This can be accessed via the intranet. In most cases the first step in receiving/processing a complaint is to talk to your supervisor.



**Audit Point 16** – *When a client complaint is received evidence of such is documented in the client's case file?*

## CRISIS MANAGEMENT

### Associated documents

- TPC Manual
- Code of Ethics of the NZ Registration Authority

50. Consideration of safety/risk and ethical concerns is a routine part of good clinical practice. The fact that these issues have been considered must be documented, not just when concerns have been raised.
51. When a staff member has concerns for a client's safety or the safety of an identifiable other (including staff) as a result of either an act of commission or omission it is imperative that,

- a) the nature of the concern be documented immediately,
- b) the staff member receives immediate supervision, often while the client is still at the Centre,
- c) a detailed management plan is included in the file,
- d) documentation, including the management plan, is countersigned by the client (where possible) and the staff member's supervisor.



**Audit Point 17** – *Documentary evidence exists on the client's file that safety/risk issues have been routinely considered.*



**Audit Point 18** – *Where a safety issue has been recognised the actions outlined in paragraph 51, and any associated documents.*

## DISCHARGE

### Associated documents

- TPC Manual

52. The decision to discharge a client should be planned. Such a decision should be made in consultation with the client and the practitioner's supervisor, and should be carefully documented. Discharge can result from (for example),
- a) the completion of a specific and specified piece of work, e.g., a neuropsychological assessment,
  - b) the client's desire to terminate their contact with the service,
  - c) limited progress being made and the caseworker assessing that further progress is unlikely to be made,
  - d) the client's inability to engage in the assessment/intervention process, e.g., repeated non-attendance.
53. When appropriate the client's family or other support people should be involved in the discharge planning process.
54. Planned discharge, as opposed to a client simply opting out of treatment by failing to attend appointments, should include a plan for documenting the discharge, i.e., who reports and letters will be sent to, and what details these should contain. Planned discharge should also include clear information about where to seek help in future should problems recur. This should make explicit whether TPC is able to offer further assistance and, if so, how to access this.
55. Appropriate documentation must be completed. This must include,
- a) a brief 'courtesy' letter to the original referrer (this can be more detailed if necessary and it has been negotiated with the client),
  - b) a treatment summary report must be lodged in the client's case file,
  - c) all case file notes must be up-to-date,

- d) a full discharge report must be completed if required (generally only for complex cases where a referral-on is being made).
56. Copies of relevant documentation should be sent to the client if appropriate.
57. The TPC database must be updated to include all client contact information, and then 'closed off' to show the client as '**Inactive**'.
58. The closed client case file should be passed to the Administrator for filing, and so that a Client Satisfaction Survey Form can be dispatched.



**Audit Point 19** – *There is evidence in the client's case file that discharge has been planned, with a clear rationale for discharge being given.*



**Audit Point 20** – *At the time of discharge all file documentation is up-to-date. All necessary letters and report have been filed, with copies sent to the client as appropriate.*



**Audit Point 21** – *The client's database record is up-to-date, and has been closed off.*

## AUDIT

59. To ensure that minimum standards of case management are maintained, and that there is consistency in the way that cases are managed, this protocol will be monitored by way of an audit process. This will help practitioners identify areas where they are not meeting the requirements of this protocol, and will help us identify areas of this protocol which require review and re-writing. **The focus of this audit is Quality Assurance, not performance management.**
60. The Director can initiate an audit of selected client files at any time. Notification will be given by email and will specify the case selection criteria to be used for file selection, e.g., the first client you saw this week, and when the file should be made available, usually the end of the present working day. No special effort is required on the part of the practitioner to prepare the file for auditing.
61. The Director will audit the files using the self-audit checklist, which can be found at the end of this document, and return a copy of the form to the practitioner (along with the file) and his/her supervisor.

## TPC CASE MANAGEMENT AUDIT FORM

**Instructions:** This audit form provides a system for supporting practitioners in reviewing against the minimum standards established at The Psychology Centre. Where practice deviates from the standards set out in this documents, as identified via the audit process, the practitioner should review the case to ensure that deviation from protocol is merited.



When undertaking a self-audit the practitioner should identify the last client he/she met with before receiving the audit request, this client becomes the 'audit focus'. The practitioner is then required to work through the audit form indicating areas of 'compliance'. Completed audit forms should be signed and returned to the Director. In the case of Supervisor or Director audits the specified case file should be passed to the Supervisor/Director, who will conduct the audit.

**Practitioner:** \_\_\_\_\_ **Client:** \_\_\_\_\_ **Date of audit:** \_\_\_\_\_

**Auditor:** Self  Supervisor  (Name: \_\_\_\_\_ ) Director

	Audit Point	Relevant paragraphs	Compliance (Yes/No) and comments
<b>1</b>	<i>Was the referral presented at the clinical staff meeting?</i>	<b>3 - 4</b>	Date: _____
<b>2</b>	<i>Have relevant client details been entered into the Referral Book (including the date when the referral was received)?</i>	<b>5</b>	Date: _____
<b>3</b>	<i>Have relevant administrative tasks related to accepting/declining the referral been completed?</i>	<b>6 - 9</b>	File: <input type="checkbox"/> Database: <input type="checkbox"/> Waitlist letter: <input type="checkbox"/> (date _____ )

<b>4</b>	<i>If an appointment/confirmation letter has been sent, does it cover all the points raised in paragraph 13?</i>	<b>15</b>	Video: <input type="checkbox"/> Fee: <input type="checkbox"/> Designation: <input type="checkbox"/> Supervision: <input type="checkbox"/> .
<b>5</b>	<i>Have appropriate consents been obtained?</i>	<b>18</b>	Video: <input type="checkbox"/> Liaison: <input type="checkbox"/> Release of information: <input type="checkbox"/> .
<b>6</b>	<i>Have the required letters been sent to the appropriate people at the time of the first appointment, at the end of the assessment, and at discharge?</i>	<b>19</b>	
<b>7</b>	<i>Are all case notes, a) legible? b) signed/designated/ dated? c) complete (plan/content/outcome)? d) countersigned (if applicable)?</i>	<b>21 - 24</b>	a) b) c) d)
<b>8</b>	<i>Is the contact sheet up-to-date? Does it tally with the case notes in the file and entries on the TPC database?</i>	<b>25</b>	
<b>9</b>	<i>Has the client been entered onto the TPC database (including at least - name, address, contact phone, date of birth, ethnicity, referral source, GP contact)?</i>	<b>25</b>	
<b>10</b>	<i>Has an assessment report been filed at the appropriate time? For students/interns - if a confirmed report is on file has it been countersigned by the supervisor?</i>	<b>27</b>	
<b>11</b>	<i>Has the OQ45 been used?</i>	<b>28</b>	

<b>11</b>	<i>Is there clear indication which letters/reports have been copied to the client/referrer? If copies have not been supplied to the client there should be a documented reason for this.</i>	<b>29</b>	
<b>12</b>	<i>Are cancellations and DNAs recorded on the contact sheet?</i>	<b>30</b>	
<b>13</b>	<i>If information has been released to the client or a third party – have the appropriate request/consent forms placed on the file? Has the exact nature of the disclosed information been specified?</i>	<b>34, 43</b>	
<b>14</b>	<i>Arrangements are in place to collect appropriate fees from/for clients. Fee payment is documented and receipts issued as appropriate.</i>	<b>44, 48</b>	
<b>15</b>	<i>When a client complaint is received evidence of such is documented in the client's case file?</i>	<b>49</b>	
<b>16</b>	<i>Documentary evidence exists on the client's file that safety/risk issues have been routinely considered.</i>	<b>50</b>	
<b>17</b>	<i>Where a safety issue has been recognised the actions outlined in paragraph 51, and any associated documents.</i>	<b>51</b>	

<b>18</b>	<i>There is evidence in the client's case file that discharge has been planned, with a clear rationale for discharge being given.</i>	<b>52</b>	
<b>19</b>	<i>At the time of discharge all file documentation is up-to-date. All necessary letters and report have been filed, with copies sent to the client as appropriate.</i>	<b>55 - 56</b>	
<b>20</b>	<i>The client's database record is up-to-date, and has been closed off.</i>	<b>57</b>	

**Additional comments:**