

Athenree Life Limited - Athenree Life

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:	Athenree Life Limited
Premises audited:	Athenree Life
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 4 November 2021 End date: 5 November 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	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

Athenree Life Limited provides rest home, hospital and dementia level care for up to 43 residents. The service is operated by Sound Care Group and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the Bay of Plenty District Health Board. 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.

No areas for improvement were identified during the audit.

Consumer rights

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

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

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


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

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

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

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 and risk management plans included the direction, goals, values and mission statement of the organisation and the facility. These included the care and support needs of the different groups of residents living at Athenree. 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 to all residents, including those younger people with disabilities, and were 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 liaison evident between the Needs Assessment Service Co-ordinator and the clinical team. Relevant information is provided to the potential resident and their family to facilitate admission to the facility.

The residents' needs are assessed by the multidisciplinary team on admission and within the required time frames. Care plans are individualised, based on a comprehensive range of information, and accommodate any new problems that might arise. The residents' files reviewed evidenced that the care provided, and the needs of the residents are reviewed and evaluated on a regular

and timely basis. Residents are referred to other health providers as required. Shift handovers and communication sheets promote continuity of care between the shifts in each area of the facility.

The planned activity programme is delivered by one full time activities assistant and is overseen by the group's national diversional therapist. The programme provides the residents with a variety of individual and group activities and maintains their links with the community. There is a facility van available for outings as Covid-19 allows.

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There was 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 are safely stored. Personalised equipment for younger people with disabilities is well maintained and safely stored in their rooms. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment, maintaining sufficient supplies and attend regular evacuation drills. The service's emergency plan considers the special needs of all residents. Fire evacuation procedures are regularly practised. Residents and families 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. There were no restraints in use at the time of the audit. The use of enablers is voluntary for the safety of residents in response to individual requests.

A comprehensive assessment, approval and monitoring process is available for the use and oversight of restraint if needed. 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.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent, and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed if required.

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

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

Covid-19 related processes are in place to manage the changes in the Ministry of Health Covid-19 response levels as appropriate to the aged care guidelines.

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	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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>Athenree has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). 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 part of the ongoing yearly training programme, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principals and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs and outings. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents is defined and documented, as relevant, in the resident's record. All residents' files reviewed in the Dementia facility have an EPOA in place and these have been activated. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed gaining consent for day-to-day care on an ongoing basis</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the service are on display and available throughout the facility in both English and Māori. Family members and residents spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff are also aware of how to access the Advocacy Service if this is required. A member of the Health and Disability Advocacy Service has visited the facility and provided education.</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>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment. The facility encourages visits from family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaint policy clearly described the complaint management process, including timeframes, and included information that complies with right 10 of the Code. Information about complaints is included in the admission agreement.</p> <p>There have been six complaints made since the current operators have taken over in December 2020. There is a register of complaints. This includes all the actions taken and records the time frames as required in the Code. Since the last audit, there have been no complaints made to the Health and Disability Commissioner or formal complaints to the DHB.</p> <p>There are complaints/compliments forms available at reception for people to use whenever they want them.</p> <p>A group of eight staff members were interviewed and they described the complaint process and their responsibilities for supporting residents and family/whanau who want to make a complaint. The facility manager was also able to describe their responsibilities for ensuring all the timeframes of the Code are met and the director or the general manager are notified verbally when this is appropriate.</p> <p>Family/whanau interviewed reported that they were aware of the process for making a formal complaint. The facility manager reported that she is available at all times to family if they wish to discuss anything and is open to feedback.</p>
<p>Standard 1.1.2: Consumer Rights</p>	<p>FA</p>	<p>When interviewed, the residents and family/whanau of Athenree reported being made aware of the</p>

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in English and Māori throughout the facility. Information on how to make a complaint and provide feedback is available for residents and families.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and their families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to personal cares, by ensuring residents' information is held securely and privately, when exchanging verbal information and during discussion with families and the GP. With the exception of one shared, double bedroom, all residents have a private room. There are several lounges located throughout the facility providing quiet areas to chat, away from the main communal areas.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and quite often the community activity comes to them as Covid-19 restrictions allow. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs have been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to be occurring during the orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There are four residents at Athenree whom identified as Māori. Staff receive annual education to enable them to support residents who identify as Māori to integrate their cultural values and beliefs. This is evident throughout the facility with the use of te reo Māori language on signage. The principals of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whanau. There is a current Māori health plan and guidance on tikanga best practice is available and there are staff who identify as Māori in the facility and can act as a resource.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's</p>	<p>FA</p>	<p>Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. There are several staff who can act as interpreters if required.</p>

<p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>Access is also available to an external service. Residents' personal preferences required interventions and special needs were included in all care plans that were reviewed. For example, likes and dislikes, and attention to preferences around activities of daily living.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. The facility general practitioner also expressed satisfaction with the standard of services provided to the residents. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service provides and encourages good practice through evidence-based policies, input from external specialist services and allied health professionals, for example the dietitian, podiatrist, psychiatrist, and education for staff. The GP confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported that they receive management support for external education and access their own professional networks. Ongoing yearly training is provided both in-house, online and through external providers.</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>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, they are advised in a timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the residents' records that were reviewed and family communication sheets. There was also evidence of resident/family input into the care planning process and the multi-disciplinary meetings.</p> <p>Staff understood the principals of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff knew how to access an interpreter should this be required, and several staff members are bi-lingual.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the</p>	FA	<p>Athenree Life Limited (Athenree) is one of four aged care facilities in Sound Care Group. There is a current business plan, which is reviewed annually, and outlines the purpose, values, scope, direction</p>

<p>organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>and goals of the Group. The documents described longer-term objectives and the associated operational plans. A sample of the facility manager's (FM's) monthly reports to the senior management team and owner showed that adequate information to monitor performance is reported including occupancy/financial performance, emerging risks and issues, recruitment and staffing issues, if any.</p> <p>The owner and director of Sound Care Group is an overseas trained nurse who now holds New Zealand registration. The facility manager is an overseas registered nurse who has worked in New Zealand as a caregiver in aged care, specialising in dementia care since 2009. She has obtained a Certificate in Healthcare at Level 4 on the New Zealand Qualifications Authority (NZQA) framework and the Dementia Unit Standards. The facility manager attends relevant training through the DHB as well as internal training through the organisation. She confirmed knowledge of the sector, regulatory and reporting requirements, and maintains currency through attending local sector meetings, building and maintaining relationships and through her role in the management team of the Sound Care Group. As well as the owner, the facility manager is supported by a clinical manager. This role is currently vacant but is being filled by the clinical support manager for the Group. There is also a general manager (GM) for Sound Care Group who is available to support the facility.</p> <p>The service holds contracts with the Bay of Plenty DHB for long term support chronic health conditions (LTCHC), aged-related residential care, hospital, rest home and dementia care. On the day of the audit there were 42 people receiving services at Athenree; 15 residents receiving hospital level care, 13 rest home care, 13 dementia care and 1 resident was assessed as LTCHC.</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>	<p>FA</p>	<p>There is adequate cover for both the facility manager and the clinical nurse manager when either person is away from the facility. In the absence of the facility manager the general manager will fill in for them. In the absence of the clinical nurse manager an appropriately skilled member of the executive management team will be assigned to this position. This was demonstrated during the audit.</p> <p>The role of clinical manager was vacant at the time of the audit and was being fulfilled by the overall clinical manager for Sound Care Group. Staff members reported that they were receiving appropriate support from the person covering the role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk</p>	<p>FA</p>	<p>The organisation has a quality and risk plan that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, internal audit activities, an annual resident satisfaction survey (due each December), monitoring of clinical incidents including infections, wounds, enablers and use of alternatives to restraints, to ensure that restraint is not occurring.</p>

<p>management system that reflects continuous quality improvement principles.</p>		<p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at both the facility with their staff meetings and group wide management meetings. Staff members reported their involvement in quality and risk management activities through reporting of incidents and accidents, assisting residents of family/whanau to make a complaint or raise concerns and involvement in internal audit activities. Relevant corrective actions or quality improvement plans are developed and implemented to address any shortfalls.</p> <p>The annual resident and family satisfaction survey is due to be completed in December. However, a post-admission survey is completed six weeks after entry of a new resident. These were reviewed for 2021. All responses were positive for people's rooms, meals, the care being provided and follow-up.</p> <p>Policies reviewed for the facility covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The owner described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The owner and facility manager are familiar with the Health and Safety at Work Act (2015) and requirements have implemented at the facility.</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 incident forms reviewed 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 by the facility manager to the GM who provides the data summary and analysis to the executive management team's monthly meeting.</p> <p>The GM and facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the current owner took over management of the facility on 23rd December 2020.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	<p>FA</p>	<p>Human resource 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 (nine) confirmed the organisation's policies are being consistently implemented and records are maintained.</p>

<p>employment 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, followed by annual appraisals with a six monthly meeting during the year.</p> <p>Continuing education is planned on an annual basis including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The facility manager is the internal assessor for the programme. Care staff working in the dementia care area have either completed or are enrolled in the required education.</p> <p>All the currently employed registered nurses are trained and competent to undertake interRAI assessments and have met their annual competency requirements. The facility manager is trained and competent as an interRAI administrator.</p> <p>Records reviewed demonstrated completion of the required training and completion of annual performance appraisals and three monthly post recruitment 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. An afterhours, on-call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. The resident and family members interviewed supported this. Registered nurses have requested 12 hour shifts as a preference. This gives them more days off and a better work/life balance.</p> <p>Observations and review of the weekly roster for the month of the audit confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on every duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p> <p>Additional healthcare assistants have been allocated to each morning shift and work has been done to establish clear task lists for each of the three healthcare assistants on the morning shift. Staff members reported that this has improved their understanding of responsibilities. Residents and family members interviewed confirmed satisfaction with care provided.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person stamped beside the entry.</p> <p>Archived records are held securely on site and are readily retrievable. Residents' records are held for the required period before being destroyed. No personal or private resident information was on display during the audit</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents are admitted to Athenree following assessment from the Needs Assessment Service Co-ordinator (NASC), as requiring the levels of care that Athenree provide. For those residents in Dementia care, all appropriate consents were in place and signed by the EPOA's as was the admission agreements. Prospective residents and their families are encouraged to visit the facility prior to admission and are provided with written information about the service. All residents prior to admission have a Covid-19 screen and the facility are guided by MOH guidelines.</p> <p>Family members interviewed stated that they were happy with the admission process and the information that had been provided to them. Files reviewed contained the completed demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Bay of Plenty District Health Board's 'Yellow envelope' system to facilitate the transfer of residents to and from acute care settings. There is open communication between all services, the residents, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, is provided for ongoing management of the resident. All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The Medication Management Policy was current and identified 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. An RN</p>

		<p>and carer check the medications against the prescription, then sign and dates each pack into the electronic system. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries. Controlled drugs are signed in and a pharmacy check is carried out every six months and this occurred when the facility changed pharmacies in the first six months and is booked in for this month.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had temperature checks taken at the time of the audit.</p> <p>Good prescribing practices were noted, these included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. There are no standing orders or verbal orders used; all charting of medications is electronic. Vaccines are not stored on site. The required Covid-19 vaccines have been given to both staff and residents with the exception of those who did not want to be vaccinated. There are currently no residents, self-medicating, there is a process in place should any residents wish to be accessed to self-medicate.</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 a cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician in June 2021 with recommendations made at the time addressed. This is due for review in 2022.</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 Western Bay of Plenty District Council. At time of audit, the kitchen was observed to be clean, and the cleaning schedule was maintained.</p> <p>Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan using an electronic database.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is</p>

		<p>available.</p> <p>Evidence of resident satisfaction with meals was verified by residents and families/whānau interviewed, through satisfaction surveys and in residents' 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 resident does not meet the entry criteria, there are no vacancies, or the referral has been declined from the service due to inappropriate referral from the Needs Assessment Services Co-ordinator (NASC), there is a process in place to ensure that the prospective resident and family are supported to find an appropriate alternative.</p> <p>If the needs of the resident change and they are no longer suitable for the services offered a referral for reassessment is made to NASC and a new placement is found in consultation with the resident and the whanau/family. This was discussed with the acting clinical manager, but at the time of the audit, this had not occurred.</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 of Athenree are assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, cognition and behaviour, nutrition, activities, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require.</p> <p>Interviews, documentation, and observation verified the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity</p>	FA	<p>Care plans at Athenree are paper based. When reviewed they reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p>

of service delivery.		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 was documented and verbally passed on to relevant staff. The two files reviewed in the Dementia facility each had a detailed 24-hour behavioural plan in place specific to the residents individual needs. Residents and family/whanau reported participation in the development and ongoing evaluation of care plans.
<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>	FA	<p>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The GP interviewed confirmed that medical orders were carried out in a timely manner and staff were very proactive at contacting the GP should a resident's condition change. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources were available and suited to the levels of care provided and in accordance with the resident's 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>	FA	<p>The activities programme for the rest home, hospital and dementia facility is provided by one full time activities assistant 9 am to 4.30 pm Monday to Friday. The programme is overseen and developed in conjunction with the national group diversional therapist. As part of the quality improvement plan, a submission to employ another activities assistant to support the residents during the week and weekends has been put forward. The activities assistant is currently completing their diversional therapist qualification supported by the national group diversional therapist.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities programme is evaluated monthly at the residents' meeting; this ascertains residents' likes and dislikes. A monthly tick list is completed along with the progress notes, all of which form part of the six-month multidisciplinary care plan review.</p> <p>Residents in the dementia facility have an in depth 24-hour diversional therapy plan and an assessment on admission to enable staff to better care for them and understand their needs. There are two residents who identify as Māori, and support is given for activities culturally appropriate for them. It is the aim of the diversional therapists to get the residents engaging in the community as much as Covid-19 restrictions allow. There is a facility van available for drives on a weekly basis for rest home, hospital and dementia care residents. At present this is not occurring due to Covid-19 restrictions.</p>

		<p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'Housie', knitting and visiting entertainers, pet therapy, walking group. There is individual, group and gender specific activities for female and male residents. Hospital and rest home residents have a separate activity programme from the dementia care residents. There are several lounge areas, as well as the individual's bedrooms where residents can watch their own television or listen to the radio. The Activities Calendar is on display and each resident is given a copy of the monthly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular basis.</p> <p>Residents and families can evaluate the programme through day-to-day discussions with the activities co-ordinator and by completing the six-monthly resident satisfaction survey and at the six monthly multi-disciplinary team meeting. Residents and families interviewed confirmed the programme was interesting and varied.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI/clinical reassessment or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans are consistently reviewed for infections, pain, weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Residents and families/whanau 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) 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>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has one main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals were sighted in the residents' files, including to the dietitian. The resident and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as ringing an ambulance if the situation dictates.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<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.</p> <p>Staff members were asked about the effectiveness of the cleaning and laundry products. There has been a change to a new contracted provided during 2021 and all reported an improved result using the new products. This included both better cleaning and a reduction in the 'chemical' smell of the product now in use, which staff members thought was better for residents.</p> <p>There is provision and availability of protective clothing and equipment throughout the facility. Staff were observed using these items during the days of the audit.</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>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 10th December 2021) was publicly displayed.</p> <p>Appropriate systems are 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 and confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment.</p> <p>The environment was hazard free and residents' safety was promoted. Personalised equipment is available for the younger residents with disabilities to meet all their mobility and equipment needs.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting. A secure and accessible garden is available directly from the dementia unit. This has seating, shade, a large, established tree and lawn. It is also private and spacious.</p> <p>Internally the dementia unit has a wide central corridor and a very large, spacious dining and living room. Residents who use the dementia unit were seen accessing these areas during the days of the audit, as well as their own bedrooms, either independently where they are able to, or with assistance if needed.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. The staff members responsible for maintenance have an annual plan of routine maintenance and daily maintenance tasks, which are signed off when completed. Completion of maintenance is reported to the facility manager each month.</p> <p>Residents and family members interviewed, or who had completed the post admission surveys, 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 a combination of en-suites, additional showers and toilet facilities and a separate toilet and shower for staff members. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote each 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. One bedroom provides shared accommodation for two residents, otherwise all other bedrooms provide single accommodation. For the two residents in the shared bedroom, approval has been sought and was sighted.</p> <p>Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is space 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 dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. There is consideration of their compatibility with residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to</p>	FA	<p>Laundry is undertaken onsite in a dedicated laundry by dedicated staff members. Family members will take specific items home for special laundering. If requested this is preferred. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen.</p> <p>Post-admission survey feedback noted that laundry is managed well, and residents' clothes are</p>

<p>the setting in which the service is being provided.</p>		<p>returned in a timely manner.</p> <p>The designated cleaning and laundry team have received appropriate training. This includes the use of the new cleaning products, infection prevention and control and training on the Code. Cleaning and laundry protocols are documented and there is a task list for each position. The staff members who were interviewed confirmed that these protocols are followed, and review of training records confirmed completion of required training.</p> <p>Chemicals were stored in secure locations and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. There is an emergency management plan based on civil defence planning which directs the facility in their preparation for disasters. This plan describes the procedures to be followed in the event of a fire or other emergency.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 25 September 2006. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 28th May 2021. 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 BBQs were sighted and meet the National Emergency Management Agency recommendations for the region. Water storage tanks are located around the complex. The facility has a relationship with the local volunteer fire brigade, and this is part of their emergency plan. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. The call bell system has been upgraded so that the two systems are now connected, and the emergency call bell has a different tone and can be heard throughout the facility. The new owner has also had larger screens installed for the call system.</p> <p>Staff members interviewed reported that the combination of these upgrades have significantly improved the call system. Call system audits are completed on a regular basis and 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, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and wall-mounted electric heaters.</p> <p>Heating is provided by heat pumps in the communal areas. Areas were an appropriate temperature and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable level of heat or ventilation, depending on the time of year.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Athenree implements an infection prevention and control programme which is appropriate for the size and complexity of the service. A comprehensive and current infection control manual is available to staff and managers. There is evidence that formal reviews of the programme are completed annually.</p> <p>The registered nurse is the designated infection prevention and control co-ordinator (ICN), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported through to management. Infection prevention and control matters are also discussed at registered nurse meetings, staff handovers, staff meetings and ultimately at management meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities and confirmed this had been further reinforced since the Covid-19 pandemic emerged with a documented process for each of the alert levels.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICN has the appropriate skills, knowledge and qualifications for the role. Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the GP and the public health unit, as required. The co-ordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>There is a Covid-19 management plan in place which details all the actions required by the service streams within the facility in response to each of the alert levels. The ICN and acting clinical manager confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p>	<p>FA</p>	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing and clearly documented on each policy the next review date. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate</p>

<p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>use of hand sanitisers, good handwashing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are distributed around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and in ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training was documented and evaluated to ensure it is relevant, current and understood. A record of attendance was maintained. At the time of the audit there had been no infection outbreaks.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Evidence: Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at staff meetings and during shift handovers. A good supply of personal protective equipment was available and Athenree has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of this standard and provide guidance on the safe use of both restraints and enablers. There is a complete suite of policies and procedures available should restraint use be required. However, the clear philosophy of the facility is to explore all alternatives to the use of restraint and to safely support a resident with those alternatives. The Group's overall clinical manager was interviewed as well as the Athenree restraint coordinator, who</p>

<p>minimised.</p>		<p>is new to this role. The overall clinical manager provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice of restraint minimisation and safe practice.</p> <p>At the beginning of 2021 there were three residents with restraints in place and now there are no residents using restraints. The file for one of the three residents who is still at the facility was reviewed. Alternatives to restraint have been trialled with the consent of the resident's family and were successful. The resident had been using bed sides for safety. Now that they have been removed and use a low-low bed and sensor mat. They are no longer experiencing incidents caused by the bed rails. They are comfortable and safe in bed and have had no falls or other type of incident or accident. The other two residents who were using restraints at the beginning of 2021 died earlier in the year and so they were not part of the trial to reduce the use of restraints.</p> <p>The use of restraints (when they have been in used in the past) and enablers is reported in the facility manager's monthly report to the executive management team. Statistical information on the use of restraints and enablers was sighted during 2021, including the reduction in restraint use and the current absence of restraints in use at Athenree.</p>
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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.