

# Mary Doyle Healthcare Limited - Mary Doyle Lifecare

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## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

The audit has been conducted by BSI Group New Zealand Ltd, 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 0.4 of the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

You can view a full copy of the standard on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Mary Doyle Healthcare Limited
<b>Premises audited:</b>	Mary Doyle Lifecare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 4 April 2023      End date: 5 April 2023
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	142

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six sections contained within the Ngā Paerewa Health and Disability Services Standard:

- ō tatou motika | our rights
- hunga mahi me te hanganga | workforce and structure
- ngā huarahi ki te oranga | pathways to wellbeing
- te aro ki te tangata me te taiao haumarū | person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita | infection prevention and antimicrobial stewardship
- here taratahi | restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. 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 subsections applicable to this service fully attained with some subsections exceeded
	No short falls	Subsections 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 subsections applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some subsections applicable to this service unattained and of moderate or high risk

## General overview of the audit

Mary Doyle Healthcare Limited - Mary Doyle Lifecare is part of the Arvida Group. The service is certified to provide rest home, hospital (medical and geriatric), and dementia level care for up to 161 residents. On the day of the audit, there were 142 residents. Arvida Group is an experienced aged care provider and there are clear procedures and responsibilities for the safe management of residents at all levels of care.

This surveillance audit was conducted against a sub section of the Ngā Paerewa Health and Disability Services Standard and the services contract with Te Whatu Ora – Health New Zealand Te Matau a Māui Hawkes Bay. The audit process included a review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family/whānau, staff and management.

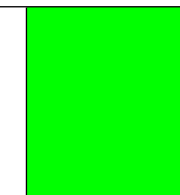
Mary Doyle Lifecare is managed by a village manager who is suitably qualified and experienced. The village manager is supported by support office staff and clinical coordinators who provide leadership for each unit. The residents and family/whānau interviewed are satisfied with the care and services provided.

The service has addressed the two of the four previous certification shortfalls relating to advance directives, the quality programme, performance appraisals and interventions.

Improvements continue to be required around the implementation of the quality programme and completion of annual performance appraisals.

This surveillance audit identified further improvements required around implementation of the quality system, medication management, restraint competencies and implementation of infection control policies.

## Ō tatou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people’s rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Subsections applicable to this service fully attained.
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The service is committed to supporting the Māori health strategies by actively recruiting and retaining suitably qualified Māori staff. There is a documented Māori health plan that supports and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori. There is a documented Pacific health plan. The service provider recognises Māori mana motuhake.

The Arvida Living Well model of care is strengths-based and ensuring wellbeing outcomes for Māori.

There is an established system for the management of complaints that meets guidelines established by the Health and Disability Commissioner.

## Hunga mahi me te hanganga | Workforce and structure

Includes 5 subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The Arvida Group has an overarching organisational plan with clear business goals and milestones to support organisational values.

The business plan includes a mission statement and operational objectives. The business plan is supported by quality and risk management processes. Internal audits are documented with corrective action plans. Monthly reporting is provided to the leadership team. Services are planned, coordinated and are appropriate to the needs of the residents. Residents receive appropriate services from suitably qualified staff.

A health and safety programme is implemented. Hazards are managed. Incident forms are documented, and results are analysed.

Human resource policies are documented. An orientation programme is in place for new staff. An education and training plan is implemented. There is a staffing and rostering policy. Policies and risk management plans are implemented to ensure safe measures related to roster cover.

## Ngā huarahi ki te oranga | Pathways to wellbeing

Includes 8 subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.

Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurses are responsible for each stage of service provision. There is evidence of family/whānau participation in care and treatment provided. Care plans demonstrate service integration. Resident files included medical notes by the contracted general practitioner and other visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medication complete education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

An activities programme is implemented. Cultural, traditional, and religious food practices are respected.

Transfer, exit, and discharges occur in a coordinated manner.

## Te aro ki te tangata me te taiao haumaruru | Person-centred and safe environment

Includes 2 subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.

Subsections applicable to this service fully attained.

The building has a current warrant of fitness, and an approved fire evacuation scheme is in place. Fire drills occur six-monthly. There is a planned and reactive maintenance programme in place. Security arrangements are in place. Visitors and staff are clearly identifiable. There is a printed up-to-date resident list for evacuation purposes.

## **Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship**

<p>Includes 5 subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.</p>		<p>Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Infection prevention management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon and evaluated. The service has robust pandemic and Covid-19 response plans in place. The service has access to personal protective equipment supplies. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. There are documented policies and procedures for the implementation of cleaning and laundry services.

## Here taratahi | Restraint and seclusion

Includes 4 subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.

Subsections applicable to this service fully attained.

There is governance commitment to support a philosophy of a restraint-free environment. The restraint coordinator is the registered nurse. There were five residents listed as using a restraint during the audit. There is leadership commitment to work towards providing a restraint-free environment. The service considers least restrictive practices, implementing de-escalation techniques and alternative interventions, and only uses an approved restraint as the last resort. The restraint policy acknowledges cultural considerations.

## Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	17	0	3	4	0	0
Criteria	0	75	0	6	4	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)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0



# Attainment against the Ngā Paerewa Health and Disability Services Standard

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

There may be subsections in this audit report with an attainment rating of ‘not applicable’ which relate to new requirements in Ngā Paerewa that the provider is working towards. The provider will be expected to meet these requirements at their next audit.

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

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	FA	<p>On interview, the village manager stated the organisation supports increasing Māori capacity by employing Māori staff members when they do apply for employment opportunities at Arvida Mary Doyle. At the time of the audit, there were staff members who identify as Māori. Wellness partners (caregivers) interviewed confirmed that the organisation welcomes the appointment of suitably qualified Māori staff. The Māori health plan has a set of actions to address barriers to Māori accessing care and employment within Arvida. The principles of these actions are also applied to people with disabilities. Ethnicity data is gathered when staff are employed, and this data is analysed at a national level.</p>
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p> <p>Te Tiriti: Pacific peoples acknowledge the mana whenua of</p>	FA	<p>The Pacific Way Framework (PWC) is the chosen model for the Pacific health plan and Mana Tiriti Framework. There are four stages identified for the implementation of the Pacific health plan and include setting the foundations, develop commitment, deliver the action plan, and</p>

<p>Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.</p> <p>As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.</p>		<p>providing leadership.</p> <p>The aim is to uphold the principles of Pacific people by acknowledging respectful relationships, valuing family/whānau, and providing high quality healthcare. The service has a Pacific advisor that will assist in the implementation of their Pacific health plan. Mary Doyle partners with their Pacific staff to guide them in the implementation of cultural safe care.</p>
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>The service strengthens the capacity for recognition of Māori mana motuhake and this is reflected in the Māori health plan and business plan. Māori mana motuhake is recognised for all residents as far as possible, by involving residents in care planning and supporting residents to make choices around all aspects of their care.</p> <p>Nineteen care staff interviewed (seven registered nurses (five were clinical coordinators), eight wellness partners (caregivers), and four wellness leaders) and review of care plans identified that the service's care philosophy is resident and family/whānau centred and all interviewees confirmed their understanding of Māori rights.</p>
<p>Subsection 1.4: I am treated with respect</p> <p>The People: I can be who I am when I am treated with dignity and respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake.</p> <p>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.</p>	FA	<p>Arvida Mary Doyle annual training plan schedules education that meets the diverse needs of people across the service. Training on Te Tiriti o Waitangi was provided twice in 2022 to support the provision of culturally inclusive care. The organisation's orientation checklist has a section where the staff member is required to read and understand the principles of Te Tiriti o Waitangi. Māori cultural days are celebrated (including Matariki and Waitangi Day).</p> <p>The service has acknowledged a cultural care philosophy that is based on 'Te Whare Tapa Whā' in the Māori health plan. Staff are supported to learn te reo Māori through an online platform. The Code of Rights are available in te reo throughout the buildings. There are handwashing and sneezing etiquette posters in te reo in disability toilets. Staff are still working on promoting and facilitation of te ao Māori through daily activities and interaction with residents and staff through their activities programme. Policies and procedures are</p>

		reviewed to ensure that te reo Māori and tikanga practices are incorporated in service delivery at Arvida Mary Doyle.
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	FA	<p>Cultural diversity is acknowledged, and staff are educated to look for opportunities to support Māori. The organisational plan and Māori health plan documents milestones and objectives related to wellbeing outcomes for Māori. Specific cultural values and beliefs are documented in the resident's care plans and this is the foundation of delivery of care, by using a strengths-based and holistic model of care, as evidenced in the resident centred care plans.</p> <p>The Māori Health plan describes how care is provided based on the four corners of Māori health `Te Whare Tapa Whā`. The Māori Health plan documents a goal to understand the impact of institutional, interpersonal, and internalised racism on a patient/resident wellbeing and to improve Māori health outcomes through clinical assessments and education sessions. The staff survey for 2022 evidenced staff satisfaction related to approachable management, positive work environment and great teamwork.</p> <p>The Arvida model of care is based on the `Attitude of Living Well` framework that covers every aspect of life: eating well, moving well, thinking well, resting well, and engaging well. Attitude of Living Well model of care supports a resident centric environment that is strengths based to improve the wellbeing of all residents.</p>
<p>Subsection 1.7: I am informed and able to make choices</p> <p>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p>	FA	<p>The service follows relevant best practice tikanga guidelines in relation to consent. The informed consent policy links to tikanga guidelines. The Māori health plan is available to guide on cultural responsiveness to Māori perspective of health. The registered nurses interviewed demonstrated a good understanding of informed consent processes. Cultural training includes best tikanga guidelines.</p> <p>Nine residents (one hospital and eight rest home) interviewed, and three family/whānau (dementia), confirmed that individual choices, independence, and cultural beliefs are respected.</p>

<p>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.</p>		<p>An advance directive policy is in place. Advance directives for health care, including resuscitation status, had been completed by residents deemed to be competent. Where residents were deemed incompetent to make a resuscitation decision, the GP or NP had made a medically indicated resuscitation decision. There was documented evidence of discussion with the EPOA. Discussion with family/whānau identified that the service actively involves them in decisions that affect their relative's lives. Discussions with the wellness partners and registered nurses confirmed that staff understand the importance of obtaining informed consent for providing personal care and accessing residents' rooms. Training has been provided to staff around Code of Rights, informed consent and EPOAs. The resuscitation status section of the advance directive form was appropriately signed, as sighted in the resident files. The previous audit shortfall (NZS HDSS:2008 # 1.1.10.7) around the signing of resuscitation forms has been addressed.</p>
<p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p> <p>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>	<p>FA</p>	<p>The complaints procedure is provided to residents and family/ whānau during the resident's entry to the service. A complaints management policy includes information on access to advocacy and complaint support systems. The Code of Health and Disability Services Consumers' Rights is visible, and available in te reo Māori, and English. Discussions with residents and family/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had, have been addressed promptly. The village manager is responsible for the management of complaints and provides Māori residents with support to ensure an equitable complaints process.</p> <p>A complaints register is being maintained. There were no complaints lodged in 2021 (since the last audit) and five for 2022 / 2023 year to date. One complaint related to an incident in February 2022 was lodged with Te Whatu Ora – Health New Zealand Te Matau a Māui Hawkes Bay, this triggered an issue-based audit completed in May 2022 by TAS and recommendations made related to employment practices. The funder has requested follow up of recommendations made in the final report, related to the management of alleged staff misconduct, management of staff complaints and improvement of performance management related documentation. Arvida Mary Doyle</p>

		<p>has made the necessary improvements required.</p> <p>One complaint made in March 2023 remains open pending further investigation. The complaints reviewed evidence no identified trends. Follow up and resolution letters link to the national advocacy service. Complaints were followed up and resolution occurred to the satisfaction of the complainant and within the timeframes and guidelines of the Health and Disability Commissioner (HDC).</p> <p>Manatū Hauora (Ministry of Health) request further monitoring of the provider's services at their next audit in relation to: 2.2 Kounga me te mōrearea (Quality and risk), 2.4 Ngā kaimahi tiaki hauora me ngā kaimahi tautoko (Health care and support workers), 3.4 Aku rongoā (My medication), 5.1 Mana whakahaere (Governance), 5.2 Te hōtaka kaupare pokenga me te whakatinanatanga (The infection prevention programme and implementation) and 5.5 Taiao (Environment).</p> <p>This audit has identified issues in relation to the quality and risk system (link 2.2.2 and 2.2.4), staff performance appraisals (link 2.4.1), medication management (link 3.4.1 and 3.4.6) and infection control (link 5.1.4 and 5.5.4).</p>
<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>FA</p>	<p>Mary Doyle Lifecare is part of the Arvida Group. The service is certified to provide rest home, hospital (medical and geriatric), and dementia level care for up to 161 residents. On the day of the audit there were 142 residents: 33 rest home residents, 58 hospital level residents, and 51 residents at dementia level of care, including one on respite care. The remaining residents were under the age-related residential care contract (ARRC).</p> <p>The service is divided across five separate units; two dementia units (64 beds including Ashcroft with 34 beds with an occupancy of 24 residents, and Goddard with 30 beds with an occupancy of 27 residents); one rest home only unit (Bramlee with 34 beds) with an occupancy of 32 residents requiring rest home level of care; and two dual-purpose units (Reeve with 37 beds and Nimon with 23 beds) with a combination of residents requiring hospital and rest home level of care (Nimon with 22 hospital residents, and Reeve with 36 hospital and one rest home resident). There are three serviced apartments certified</p>

	<p>to provide rest home level care, noting that these were not occupied on the day of audit.</p> <p>Arvida Group's Board of Directors are experienced and provide strategic guidance and effective oversight of the executive team. Terms of reference for roles and responsibilities are documented in the Business Charter. The Arvida executive team oversees the implementation of the business strategy and the day-to-day management of the Arvida Group Business. The Arvida Group comprises of eight experienced executives. The chief executive officer (CEO), chief financial officer (COO) and chief operational officer (COO) have all been inducted in their role. There are various groups in the support office who provide oversight and support to village managers including: a wellness and care team; general manager village services; procurement team; information and technology team; people and culture team; head of employment relations; and accounts personnel.</p> <p>Village managers have overall responsibility, authority, and accountability for service provision at the village. Each village manager has a support partner that provides mentoring and reports through to the senior leadership, executive team, and the Board. Arvida Group ensure the necessary resources, systems and processes are in place that support effective governance. The Board receives progress updates on various topics including benchmarking, escalated complaints, human resource matters and occupancy.</p> <p>The executive team, village manager and clinical coordinators have completed cultural training to ensure they are able to demonstrate expertise in Te Tiriti, health equity and cultural safety. There is a health equity group that is responsible for the Arvida Group overall clinical governance, reviewing and implementation of the Ngā Paerewa Services Standard. There is a separate Māori advisory committee (with eight members from different villages) that assist the Health Equity Group to improve the outcomes that achieve equity for Māori. Arvida Group have contracted a Māori consultant to support policy review, te reo, Te Tiriti and tikanga Māori training. A Pasifika liaison/cultural advisor provides the same support for Pacific peoples at Arvida Mary Doyle.</p> <p>Arvida Group have a quality assurance and risk management programme and an operational business plan. The Arvida Living Well</p>
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	<p>Community 2023 business plan is specific to Arvida Mary Doyle and describes specific and measurable goals that are regularly reviewed and updated. Site specific goals relates to clinical effectiveness, risk management and financial compliance. Quality improvements are documented around environmental improvements, communication pathways, and delivering a food experience. The business plan describes annual goals and objectives that support outcomes to achieve equity for Māori and addressing barriers for Māori. Cultural safety is embedded within the documented quality programme and staff training.</p> <p>The overarching strategic plan has clear business goals to support their philosophy of 'to create a great place to work where our people can thrive'. The strategic plan reflects a leadership commitment to collaborate with Māori, aligns with the Ministry of Health strategies and addresses barriers to equitable service delivery. The overall strategic goal is to deliver a high-quality service, which is responsive, inclusive, and sensitive to the cultural diversity of the communities that they serve.</p> <p>The management team review the progress on the business objectives and quality goals regularly to identify barriers and improve outcomes for all residents. The governance has an open and transparent decision management process that includes regular meetings with village managers.</p> <p>There is a village manager (non-clinical) that oversees the operational, financial management, HR management, property, and maintenance requirements. The village manager has previously managed aged care facilities and has been in the role since November 2022. The village manager is supported by five clinical coordinators who provide clinical governance for the facility. The clinical coordinator from the dementia unit is acting clinical manager (since October 2022). The clinical manager role is currently advertised.</p> <p>The village managers and clinical coordinator (acting clinical manager) have completed a three-day Arvida leadership programme and conference.</p>
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<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>	<p>PA Moderate</p>	<p>Arvida Mary Doyle has a documented quality and risk management programme. The documented quality and risk management system includes performance monitoring through internal audits and through the collection of clinical indicator data. Bimonthly quality improvement/management and health and safety meetings, monthly clinical meetings, quarterly staff meetings provide an avenue for discussions in relation to (but not limited to): quality data; health and safety; infection control/pandemic strategies; complaints received (if any); cultural compliance; internal audit results and corrective actions; staffing; and education. Internal audits and collation of data were documented as taking place, with corrective actions documented where indicated to address service improvements. Corrective action plans document evidence of progress; however, several corrective action plans had to be restarted and could not be signed off due to a lack of progress.</p> <p>The meeting schedule for 2022 had fallen behind. The meeting schedule for 2023 is being implemented. Due to limited evidence of staff meetings, the previous shortfall (NZS HDSS:2008 # 1.2.3.8) related to documented corrective actions raised from meeting minutes and resolution raised from meeting minutes remains open.</p> <p>There was limited evidence that staff are informed of quality data trends, analysis, and a recent outcome /result from a staff satisfaction survey.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed, with several policies in the process of being reviewed. A Māori consultant supports the review of policies. New policies or changes to a policy are communicated to staff. Policies are available on the Arvida intranet. As part of the overall annual review of the quality programme, the service reviews the annual education and competency programme for staff. Staff are supported to learn te reo and e-learning material and resources are available on the Arvida intranet. Staff completed cultural competency and training to ensure a</p>
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	<p>high-quality service and cultural safe service is provided for Māori.</p> <p>There was no documented evidence of a 2022 resident and family/whānau satisfaction survey or regular resident and family/whānau meetings being held.</p> <p>A health and safety system is in place. There is a health and safety committee with representatives from each department that meets three-monthly. Hazard identification forms are completed electronically, and an up-to-date hazard register was reviewed. Health and safety policies are implemented and monitored by the health and safety committee. There are regular meetings with the national health and safety manager. Staff incident, hazards and risk information is collated at a facility level, reported to national level and a consolidated report and analysis of all facilities are then provided to the governance body. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form. There were no serious staff injuries in the last 12 months.</p> <p>Electronic reports are completed for each incident/accident, a severity risk rating is given, and immediate action is documented with any follow-up action(s) required, evidenced in twelve accident/incident forms reviewed (witnessed and unwitnessed falls, behaviours that challenge, pressure injury, absconding, skin tears). Data is analysed by the clinical coordinators for each unit. However, there was limited evidence that the results are discussed in the quality and staff meetings. Clinical coordinators and staff interviewed confirm staff are informed at handover of residents of concern. The system escalates alerts to senior team members depending on the risk level. A notification and escalation matrix are available to staff. A summary is provided against each clinical indicator data. Benchmarking occurs on a national level against other Arvida facilities and other aged care provider groups.</p> <p>Critical analysis of organisational practice is completed through benchmarking and analysis and reports at national level, annual review of the quality programme, review of policies and internal audits.</p> <p>Each event involving a resident reflected a clinical assessment and a timely follow up by a RN. Family/whānau are notified following incidents. Opportunities to minimise future risks are identified by the</p>
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		<p>clinical managers in consultation with the allied staff, RNs, and wellness partners. Incident and accident data were collated, and trends and analysis were completed on the electronic register. Corrective actions were documented where trends were identified.</p> <p>Discussions with the village manager and clinical coordinators evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There has been one HealthCERT notification related to a change in clinical coordinator/acting clinical manager and eleven Section 31 notifications completed to notify HealthCERT in 2022/2023 year to date, including three related to the same missing medication incidents/investigation; one police involvement related to the medication incident; six pressure injuries; and one absconding resident. There have been seven Covid-19 outbreaks between March and April 2023 and one norovirus outbreak in October 2022 reported to Public Health.</p>
<p><b>Subsection 2.3: Service management</b></p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	<p>PA Low</p>	<p>Human resources policies include documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered on to manage the care requirements of the residents.</p> <p>The service has a total of 225 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The acting clinical manager (clinical coordinator for one of the dementia units) works 40 hours per week, Monday to Friday. In addition, there are a further four clinical coordinators (one for each unit). The clinical coordinators share the on call after hours duties. The GP practice provides after hour support.</p> <p>The clinical coordinators (all RNs) are all rostered on as additional staff to the RNs and rostered in a manner that the weekend is covered with at least one clinical coordinator. The clinical coordinators are aware that extra staff can be called on for increased resident requirements.</p> <p>The service is divided across five separate units. There are two separate buildings.</p> <p>i) In Ashcroft (dementia unit) with an occupancy of 24 residents, there</p>

	<p>are six wellness partners, including one medication competent team leader in the morning (four on a long shift and one on a short shift); four in the afternoon (two long shift and two short shift); and two wellness partners overnight. There is a RN five days a week in the morning and a level four medication competent team leader in the afternoon.</p> <p>ii) In Goddard (dementia unit) with an occupancy of 27 residents, there are four wellness partners in the morning (two on a long shift and two on a short shift); five in the afternoon (two long shift and three short shift); and two wellness partners overnight. In addition, there is an EN for three days on afternoon shift and a level four team leader. An RN is rostered in the afternoon and on nights seven days a week.</p> <p>iii) In Bramlee with an occupancy of 32 residents requiring rest home level of care, there are six wellness partners in the morning (five on a long shift and one on a short shift); three in the afternoon (two long shift and one short shift); and one wellness partner overnight. There is an RN for 32 hours a week in the morning. In addition, there is an EN for three days on afternoon shift and a level four medication competent team leader for four afternoon shifts.</p> <p>iv) In Reeve with 36 hospital residents and one rest home resident, there are eight wellness partners in the morning (seven on a long shift and one on a short shift); six wellness partners in the afternoon (three long shift and three short shift); and two wellness partners and one EN overnight. There is an RN on each shift.</p> <p>v) In Nimon with 22 hospital residents, there are five wellness partners in the morning (three on a long shift and two on a short shift); five in the afternoon (three long shift and two short shift); and two wellness partners overnight. In addition, there is a level four medication competent team leader in the morning. There is one registered nurse on each shift.</p> <p>There is a wellness partner who works between both Nimon and Bramlee overnight.</p> <p>There is at least two RNs on at any one time. There are 12 shifts across a fortnight that are replaced by regular agency RNs. There is one Wednesday a fortnight when the facility is overseen by two agency staff. Interviews with staff, residents and family members confirmed</p>
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	<p>there are sufficient staff to meet the needs of residents.</p> <p>There is an annual education and training schedule that has been completed for 2022 and being implemented for 2023. The education and training schedule lists compulsory training which includes cultural safe support practices in New Zealand awareness training. Cultural awareness training is part of orientation and provided annually to all staff (September 2022). External training opportunities for care staff include training through Te Whatu Ora Health New Zealand -Te Matau a Māui Hawkes Bay, and hospice.</p> <p>Staff are encouraged to participate in learning opportunities that provide them with up-to-date information on Māori health outcomes and disparities, and health equity through the annual e-learning platform education schedule and available resources on the intranet. Staff confirmed that they were provided with resources during their cultural training. The learning platform creates opportunities for the workforce to learn about and address inequities. Arvida Mary Doyle supports all employees to transition through the New Zealand Qualification Authority (NZQA) Careerforce Certificate for Health and Wellbeing. There are 121 wellness partners employed. Eighteen wellness partners have achieved level two certificate Health and Wellbeing and seventy-one have completed level three and above.</p> <p>All staff are required to complete competency assessments as part of their orientation. Registered nurses' complete competencies including restraint, medication competency (including controlled drug management, insulin administration and syringe driver training) and oxygen administration. Additional RN specific competencies include subcutaneous fluids and interRAI assessment competency. Eight of seventeen RNs are interRAI trained. All RNs are encouraged to attend in-service training and completed critical thinking and problem solving, infection prevention and control, including Covid-19 preparedness, dementia, and delirium. All RNs attend relevant quality, staff, RN, health and safety, and infection control meetings when possible. All wellness partners and enrolled nurses are required to complete annual competencies for restraint, moving and handling, personal protective equipment (PPE), medication, handwashing, insulin administration and cultural competencies. A record of completion is maintained on an electronic register. Competencies were documented as completed for</p>
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		<p>2022; however, restraint competencies have fallen behind schedule for 2022.</p> <p>There are 14 wellness partners allocated to the dementia unit; eight have completed the relevant required dementia standards and six are in progress of completing their dementia standards. All six have commenced employment within the 18-month period.</p> <p>Staff wellness is supported by Wellness New Zealand and an employee assistant programme (EAP) is available. Staff could explain workplace initiatives that support staff wellbeing and a positive workplace culture.</p>
<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	<p>PA Low</p>	<p>There are human resource policies in place, including recruitment, selection, orientation, staff training and development, management of staff performance and the management of staff misconduct. Staff files are held secure. Nine staff files reviewed (three wellness partners, five clinical coordinators, one wellness leader) evidenced implementation of the recruitment process, employment contracts, police checking, reference checking and completed orientation. There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, delegation authority, and functions to be achieved in each position. Employment agreements document the process related to the management of misconduct and serious misconduct. There is a whistle-blower policy and intranet process where staff can make a staff complaint.</p> <p>There is professional staff employed (People Team) at Arvida support office that provides support related to disciplinary matters and staff misconduct, to ensure procedural and substantive fairness according to good employment law practices.</p> <p>A register of practising certificates was sighted as maintained for all health professionals (eg, RNs, GPs, pharmacy, physiotherapy, podiatry, and dietitian). All registered nurses have a current annual practicing certificate. There is an appraisal policy as part of the human resources. An appraisal schedule is in place as part of a corrective action plan. The corrective action plan has been reviewed; progress has been made; however, there are still appraisals outstanding for nine</p>

		<p>staff. The previous audit shortfall (NZS HDSS:2008 # 1.2.7.5) around completion of performance appraisal remains open.</p> <p>All new staff have a three-month appraisal and development meeting which occurs three months after commencement of employment.</p> <p>The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. A comprehensive induction includes a training in the Attitude of Living Well (which focuses on resident led care). Competencies are completed at orientation. A team leader (level 4 wellness partner) is allocated to each unit and responsible for the implementation of the orientation programme for new wellness partners.</p> <p>The service demonstrates that the orientation programmes support clinical coordinators, RNs, ENs and wellness partners to provide a culturally safe environment to Māori. Information held about staff is kept secure, and confidential. There is a separate orientation programme available for agency RNs.</p> <p>Ethnicity data is identified, and the service maintains an employee ethnicity database. Following any staff incident/accident, evidence of debriefing, support to return to work or rehabilitation and follow-up action taken, are documented. Wellbeing support is provided to staff. Currently Arvida supports an employee assistance programme across all its sites, which is available to all staff.</p>
<p>Subsection 3.1: Entry and declining entry</p> <p>The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p> <p>As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. The service is managing bed numbers in order to maintain safe staffing ratios and is not currently accepting residents from outside of the village. There is a process in place to enable the collection of ethnicities for all residents both on admission and if a referral is declined.</p> <p>The service has established relationships with local kaumātua, Māori health services and communities to benefit Māori individuals and whānau. There are staff who identify as Māori who are available to provide support to Māori residents and whānau, and the service can</p>

<p>whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.</p>		<p>access the Māori advisor if required.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>PA Moderate</p>	<p>Seven resident files were reviewed, (two rest home, two hospital and three from dementia). Registered nurses (RN) are responsible for conducting all assessments and developing the care plans.</p> <p>All residents have admission assessment information collected and an interim care plan is completed at the time of admission. Assessments, including the interRAI assessment outcomes, form the basis of the care plans. All resident files had an initial interRAI assessment completed. Additionally, all files have a suite of initial assessments completed in electronic format to form the basis of the long-term care plan and these are reviewed regularly to capture any changes.</p> <p>However, not all files reviewed documented that interRAI assessments and long-term care plans have been documented within timeframes or updated to reflect changes to care need.</p> <p>Cultural assessment details are woven through all sections of the care plan. There is evidence of resident and family/whānau involvement in the interRAI and review of long-term care plans. This was documented in progress notes and the case conference notes. Care plan templates are holistic in nature and reflect a person-centred model of care (Attitude of Living Well) that give tāngata whaikaha choice and control over their supports. Any short-term acute issues such as infections, weight loss, and wounds, are added to the care plan. There are residents who identify as Māori whose files reviewed had appropriate cultural supports and interventions detailed in their electronic care plan. Residents' specific goals (pae ora outcomes) are documented. Behaviours that challenge are assessed when they occur.</p> <p>All residents had been assessed by a general practitioner (GP) within five working days of admission and the GP reviews each resident at least three-monthly. There are two weekly GP visits. Specialist referrals are initiated as needed. Allied health interventions were documented and integrated into care plans. The service has contracted a physiotherapist for four hours a week and when required.</p>

	<p>The GP was unavailable for interview.</p> <p>Wellness partners interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery, this was sighted on the day of audit and found to be comprehensive in nature. Progress notes are written daily and as necessary by wellness partners and RNs. The RN further adds to the progress notes if there are any incidents or changes in health status.</p> <p>Residents interviewed reported their needs and expectations were being met. When a resident's condition alters, an RN initiates a review with the GP. Families were notified of all changes to health, including infections, accident/incidents, GP visits, medication changes and any changes to health status.</p> <p>There is an electronic wound register. Wound assessments, and wound management plans with body map, photos and wound measurements were reviewed. Wound records were reviewed for five residents with current wounds. The service has eight pressure injuries logged (five residents). All have wound assessments, management plans and evaluations. The service has a documented project in place to prevent and manage pressure injuries. Input from the wound nurse specialist is accessible when required.</p> <p>Wellness partners interviewed stated there are adequate clinical supplies and equipment provided, including continence, wound care supplies and pressure injury prevention resources. There is also access to a continence specialist as required. Care plans reflect the required health monitoring interventions for individual residents. Wellness partners and RNs complete monitoring charts, including: bowel chart; blood pressure; weight; food and fluid chart; pain; behaviour; blood sugar levels; and toileting regime. Neurological observations have been completed for unwitnessed falls with or without head injuries.</p> <p>Monitoring interventions were documented as needed, including neurological observations and vital signs. De-escalation techniques for resident with behaviours that challenge was documented well in the care plans, including triggers and interventions. The shortfall identified at the previous audit around monitoring and care plan interventions (NZ 8134:2008 criteria 1.3.6.1.) has been addressed.</p>
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<p><b>Subsection 3.3: Individualised activities</b></p> <p>The people: I participate in what matters to me in a way that I like.  Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.  As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.</p>	<p>FA</p>	<p>The monthly activities calendar includes celebratory themes and events. Staff members work in ways that ensure the connection with the community is authentically maintained. The service engages with local community volunteers and visitors. The residents interviewed were complimentary of the activities provided.</p> <p>Arvida leadership group provides guidance to the service regarding opportunities for Māori to participate in te ao Māori, and activities for residents who want to be connected with te ao Māori. However, this guidance has is yet to be reflected in the activity plans for Mary Doyle.</p>
<p><b>Subsection 3.4: My medication</b></p> <p>The people: I receive my medication and blood products in a safe and timely manner.  Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.  As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA  Moderate</p>	<p>There are policies available for safe medicine management that meet legislative requirements. All clinical staff (RNs and medication competent wellness partners) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided as part of the competency process. Registered nurses have completed syringe driver training.</p> <p>Staff were observed to be safely administering medications. The registered nurses and wellness partners interviewed could describe their role regarding medication administration. The service currently uses pre-packaged medications for regular medication and ‘as required’ medications. All medications are checked on delivery against the electronic medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>Medications are stored in medication rooms for each unit. The medication fridges and room temperatures are monitored daily, and the temperatures were within acceptable ranges. All eyedrops have been dated on opening. Over the counter vitamins or alternative therapies residents choose to use, had been reviewed, and prescribed by the GP. Not all medications were dated on opening or within date. The documentation on the controlled drug register did not all meet accepted standards.</p> <p>Fourteen electronic medication charts were reviewed. The medication</p>

		<p>charts reviewed identified that the GP had reviewed all resident medication charts three-monthly, and each chart has photo identification and allergy status identified. There was one resident self-administering insulin at the time of the audit; however, not all self-medicating documentation was in place for this resident. Standing orders are not used.</p> <p>There was documented evidence in the electronic clinical files that residents and family/whānau are updated around medication changes, including the reason for changing medications and side effects. The registered nurse described working in partnership with the Māori residents (when required) and whānau to ensure the appropriate support is in place, advice is timely, easily accessed, and treatment is prioritised to achieve better health outcomes.</p> <p>The service completed three Section 31s between 4 January and 10 February 2023 related to missing medication. An internal investigation was conducted by Arvida management. The extent of the problem was shown to be significant, and a Section 31 followed to notify of police involvement. Arvida completed a full report to the medication control Board which accepted the corrective actions in the report. At the time of the audit, the investigation was still ongoing. The corrective action plan in place includes reviewing the process when medications are received by the pharmacy, and a review of the process of responsibility when creating users on the electronic medication management system.</p>
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	FA	<p>Kitchen staff are trained in safe food handling. The kitchen manager interviewed stated they can implement menu options culturally specific to te ao Māori. Kitchen staff attended cultural training with the rest of the staff. Kitchen staff and wellness partners interviewed understood basic Māori practices in line with tapu and noa.</p>

<p><b>Subsection 3.6: Transition, transfer, and discharge</b></p> <p>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.</p>	<p>FA</p>	<p>There were documented policies and procedures to ensure exiting, discharging or transferring residents have a documented transition, transfer, or discharge plan, which includes current needs and risk mitigation. Planned exits, discharges or transfers were coordinated in collaboration with the resident (where appropriate), family/whānau and other service providers to ensure continuity of care. Transfer documents are printed in a format of a pack from the electronic system and include resuscitation status, EPOA or next of kin contact numbers, latest medication chart, progress notes and most recent GP notes.</p>
<p><b>Subsection 4.1: The facility</b></p> <p>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>	<p>FA</p>	<p>The buildings, plant, and equipment are fit for purpose, and comply with legislation relevant to the health and disability services being provided. The current building warrant of fitness expires October 2023. There is a documented preventative maintenance plan and includes checking and calibration of medical equipment, testing and tagging of other electrical equipment, which occurred as required. Hot water temperatures are maintained within suitable ranges and checked monthly.</p> <p>The environment, art and decor are inclusive of peoples' cultures and supports cultural practices. There are whānau rooms available within the facility.</p> <p>The service has no plans to expand or alter the building, but will consider how designs and the environment reflects the aspirations and identity of Māori, for any new additions or new building construction that may take place in the future. The village manager interviewed stated the Arvida support office provides direction on new build projects. The independent Māori consultant provides advice, and a separate Māori Advisory Committee will collaborate and work in partnership with the Health Equity Group to ensure any decisions relating to new builds and appropriate environments for Māori, embrace the principle of Tino Rangatiratanga.</p>

<p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p>	<p>FA</p>	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service (sighted). A fire evacuation drill is repeated six-monthly, in accordance with the facility's building warrant of fitness requirements. There is a current resident list with assistance requirements documented to ensure for a smooth evacuation when required.</p> <p>The building is secure after hours, and staff complete security checks at night. Staff are identifiable and wear name badges. All visitors must sign in and complete health declarations. Contractors complete an orientation specific to the site.</p>
<p>Subsection 5.1: Governance</p> <p>The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately.</p> <p>Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance.</p> <p>As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.</p>	<p>PA Moderate</p>	<p>Infection prevention and control and antimicrobial stewardship (AMS) is an integral part of Arvida's strategic and quality plan to ensure an environment that minimises the risk of infection to residents, staff, and visitors. Expertise in infection control and AMS can be accessed through Arvida support office, a microbiologist, Public Health, and Te Whatu Ora -Te Matau a Māui Hawkes Bay. Infection control and AMS resources are accessible to staff.</p> <p>There is an infection control committee that is reflective of all head of departments and clinical coordinators from each unit that oversees the infection prevention and control (IPC) and AMS of Arvida Mary Doyle. There is a schedule of when infection control meetings need to occur that is part of the quality improvement management meetings bimonthly. However, these meetings have not occurred as scheduled for 2022, but are on track for 2023 (link 2.2.4).</p> <p>Infection rates are presented and discussed at quality improvement management meetings, clinical and combined staff meetings. Due to limited meetings in 2022, staff were not always informed of infection rates (link 2.2.4). The data is benchmarked with other Arvida facilities. The Arvida Group benchmarks with other aged care organisations and presents the results to their facilities. This information was not displayed on staff noticeboards (link 2.2.4).</p> <p>Any significant events are managed using a collaborative approach</p>

		<p>and involve the infection control coordinator, Arvida IPC lead, the senior management team, the GP/NP, and the public health team. There is a documented pathway for reporting infection control and AMS issues to the Arvida Board. The Arvida executive team knows and understand their responsibilities for delivering the infection control and antimicrobial programmes and seek additional support where needed to fulfil these responsibilities. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. Infection control is linked into the electronic quality risk and incident reporting system. The infection control and AMS programme is reviewed annually by Arvida support office, in consultation with the infection control coordinators.</p>
<p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.  Te Tiriti: The infection prevention programme is culturally safe.  Communication about the programme is easy to access and navigate and messages are clear and relevant.  As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	<p>FA</p>	<p>A registered nurse (clinical coordinator of the hospital) oversees infection control and prevention across the service since November 2022. The job description outlines the responsibility of the role relating to infection control matters and antimicrobial stewardship (AMS). The IPC coordinator is experienced with the IPC nurse role and has been previously an IPC nurse at public hospital. The infection control coordinator has completed an online MOH infection training and online Altura education. The service has access to an infection prevention clinical nurse lead from Arvida support office, microbiologist, and Te Whatu Ora -Te Matau a Māui Hawkes Bay. The IPC coordinator is part of the bimonthly IPC meetings with Te Whatu Ora -Te Matau a Māui Hawkes Bay.</p> <p>During Covid-19 lockdown and outbreak periods, there were regular zoom meetings with Arvida support office which provided a forum for discussion and support. The service has a Covid-19 response plan which includes preparation and planning for the management of lockdown, screening, transfers into the facility and positive tests. There is ample personal protective equipment, and these are regularly checked against expiry dates by the IPC coordinator.</p> <p>The infection prevention programme outlines a comprehensive range of policies, a pandemic plan including the management of Covid-19, AMS, standards, and guidelines, and includes defining roles, responsibilities and oversight, training, the built environment,</p>

	<p>management of waste, cleaning and laundry practices and education of staff. Policies and procedures are reviewed by Arvida Group support office, in consultation with infection control coordinators. Policies are available to staff.</p> <p>There are policies and procedures in place around reusable and single use equipment. Single-use medical devices are not reused. All shared equipment is appropriately disinfected between use, and this includes nail clippers.</p> <p>The procedures to check these are included in the internal audit system (IPC policy to practice audit completed in December 2022). There are sneezing etiquette and handwashing posters available in te reo Māori. There is a Māori advisor and Māori advisory committee that assist the organisation to implement cultural safe practice in relation to IPC practices. Staff interviewed were knowledgeable around providing culturally safe practices in relation to infection control, that acknowledge the spirit of Te Tiriti. The infection prevention programme related to the built environment, renovation and construction document the requirements of the Arvida Group lead for special projects and Māori advisor to include the infection control coordinators in IPC matters, when significant changes are proposed to an existing facility. There are no changes proposed for Arvida Mary Doyle in the near future.</p> <p>The infection control programme states that the facility is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and is included in the annual training plan. There has been additional training and education around Covid-19 and staff were informed of any changes through handovers, and emails. Staff have completed handwashing, N95 mask fitting and personal protective equipment competencies as part of the competency scheduled annually. Resident education occurs as part of the daily cares. Residents and families/whānau were kept informed and updated on Covid-19 policies and procedures through regular newsletters and emails. There were plenty of PPE stored and available. PPE and consumables are procured with input from the IPC coordinator and Arvida IPC clinical nurse lead.</p> <p>Visitors are asked not to visit if unwell. Visitors are requested to use</p>
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		<p>masks when entering the facility.</p> <p>The clinical nurse specialist infection prevention and control of the Covid Coordination Centre (CCC) of Te Whatu Ora –Te Matau a Māui Hawkes Bays conducted a visit on 19 August 2022 to look at the infection control practices, and documented improvements required.</p> <p>Arvida IPC lead developed a corrective action plan. An audit 'IPC policy to practice' has been developed as a result of the IPC findings. This internal audit is now used across Arvida and part of the internal audit schedule and completed bimonthly. The internal audit is completed for each unit by each clinical coordinator with oversight from the IPC coordinator. All staff received IPC training, including laundry and cleaning staff.</p> <p>There are hand sanitisers, plastic aprons and gloves strategically placed around the facility at point of care. Handbasins all have flowing soap. There were two residents in isolation with Covid-19 infection on the days of audit. There were outbreak resource packs with PPE donning and doffing posters and 'Stop' sign posters at the door and basic environmental clean posters in place. It was observed that staff were wearing PPE and N95 masks. There were separate donning and doffing areas within the door seal space.</p>
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p>	<p>FA</p>	<p>Surveillance of healthcare-associated infections (HAIs) is appropriate to that recommended for long-term care facilities and is in line with priorities defined in the infection control programme. Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the infection register on the electronic risk management system. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. This data is monitored and analysed for trends, monthly and annually. Arvida benchmark infection data against other aged care facilities.</p> <p>There was limited evidence that results of the surveillance data are shared with staff; there were no data on the noticeboards and limited evidence of meeting minutes (link 2.2.4). Staff interviewed confirm they</p>

		<p>are informed of infection rates at handover and specifically individual residents of concern. Residents and family/whānau interviewed stated they are provided feedback on their progress and outcomes should they develop a HAI, as also reviewed in the progress notes.</p> <p>Culturally safe processes for communication between the service and residents who develop or experience a HAI are practiced as sighted in the progress notes; however, there were limited evidence of infection control meetings and resident meetings minutes (link 2.2.4). All infections are collated, analysed and summaries provided. Where there are significant incidents related to infection and AMS, these are reported to the Arvida senior team and the Board as soon as possible.</p> <p>Since the previous audit, there have been seven Covid-19 outbreaks between May 2022 and March 2023 and one norovirus outbreak in October 2022. This was managed effectively with support and advice from Te Whatu Ora – Health New Zealand Te Matau a Māui Hawkes Bay, Arvida IPC clinical nurse lead and Public Health.</p> <p>The service is actively working towards including ethnicity data in the surveillance of healthcare-associated infections.</p>
<p>Subsection 5.5: Environment</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.</p> <p>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible.</p> <p>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.</p>	<p>PA Low</p>	<p>The infection control programme includes the management of environmental cleaning and laundry processing.</p> <p>There are policies regarding chemical safety and hazardous waste and other waste disposal. All chemicals were clearly labelled with the current manufacturer’s labels and stored in locked areas. Cleaning chemicals are kept in a locked cupboard on the cleaning trolleys and the trolleys are kept in a locked cupboard when not in use. Safety data sheets and product sheets are current and available in key areas, including the laundry, cleaning cupboard and sluices. Sharps containers are available and meet the hazardous substances regulations for containers. Waste bins are transported to and from the buildings using a separate entrance. Waste management and infection control is a component of the annual mandatory training and included in the initial orientation programme for new staff.</p> <p>Gloves, aprons, and masks are available for staff, and they were</p>



	<p>observed to be wearing these as they carried out their duties on the days of audit. There was hand gel available to staff at point of care and in key areas throughout the hallways. There is a sluice room with sanitizer in each area, with stainless steel bench and separate handwashing facilities. Eye protection wear and other PPE are available in the sluices, utility rooms in each area and are easily accessible to staff. Staff have completed chemical safety training. A chemical provider monitors the effectiveness of chemicals.</p> <p>There is a laundry on site in the main building with a satellite laundry for personals only in the Bramlee/Nimon area. The main laundry is operational seven days a week. There are three laundry assistants to cover the roster till 8.30pm at night. Visual inspection of the on-site laundries has a clean/dirty process for the hygienic washing, drying, and handling of these items. Linen is delivered in a hygienic manner from the main laundry to Bramlee/Nimon in a covered trolley. Personal laundry is delivered back to residents in named baskets. Linen is delivered to cupboards on trolleys. The linen trolleys were covered with a PVC linen cover when transporting clean linen from the main laundry between the two buildings. There is enough space for linen storage. The linen cupboards were well stocked, and linen is in a good condition. The washing machines and dryers are checked and serviced regularly.</p> <p>Household staff have completed specific related training to their roles, and this included environmental cleaning and the use of cleaning equipment. At the time of the audit, the household staff were observed to use cleaning equipment and products correctly as per policy. There were several antimicrobial surface cleaning wipes available at the nurse's station, in utility/equipment rooms, and at the point of cleaning required for high touch areas like iPad, phones and keyboards. Visual inspection of the environment evidence residents' rooms, ensuites and utility rooms to be uncluttered and organised. Equipment shared between residents were cleaned and in good condition; majority of the hoists were less than 24 months old with all working parts.</p> <p>There was limited evidence that residents and family/whānau were provided opportunity to give feedback on cleaning and laundry services (link 2.2.4).</p> <p>The effectiveness of the cleaning and laundry processes are monitored</p>
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		<p>through the internal audit system, with oversight from the IPC coordinator. There are documented processes on the transporting/moving of dirty linen within the facility; however, on the days of the audit, staff were observed not to follow the correct laundry handling practices.</p>
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>	<p>FA</p>	<p>There is governance commitment to support and work towards a restraint-free environment. Restraint policy confirms that restraint consideration and application must be done in partnership with families, and the choice of device must be the least restrictive possible. The restraint coordinator is the clinical manager, who provides support and oversight of restraint management in the facility. The restraint coordinator (RN) is conversant with restraint policies and procedures. There were five residents using restraint (lap belts). A register is maintained.</p> <p>An interview with the restraint coordinator described the organisation's commitment to restraint minimisation. The reporting process to the governance body includes data gathered and analysed monthly that supports the ongoing safety of residents and staff. A review of the restraint documentation available for residents requiring restraint included approval and consent processes, care planning, interventions, monitoring, and evaluation of the restraint as appropriate. Cultural considerations are included at the time of assessment and care planning. The restraint approval process includes the resident (if competent), GP, clinical manager, registered nurse and family/whānau approval. The restraint committee meets six-monthly and evaluations of the restraints in use occur three-monthly.</p> <p>Restraint is used as a last resort, only when all other alternatives have been explored. This was evidenced through interviews with staff who are actively involved in the ongoing process of monitoring. Restraint competency assessments were not up to date (link 2.3.3). The restraint coordinator described ways the service would work in partnership with Māori, to promote and ensure services are mana enhancing, if restraint was being considered in the facility.</p>



## Specific results for criterion where corrective actions are required

Where a subsection is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the subsection. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 2.2.1</p> <p>Service providers shall ensure the quality and risk management system has executive commitment and demonstrates participation by the workforce and people using the service.</p>	PA Low	<p>The business plan for Arvida Mary Doyle 2023 describes annual goals and objectives that support outcomes to achieve equity for Māori and addressing barriers for Māori. Cultural safety is embedded within the documented quality programme and staff training.</p> <p>The governance and management team aim to have an open and transparent decision management process that includes residents' meetings; however, there was no evidence of resident, family/whānau satisfaction survey or resident meeting minutes for 2022.</p> <p>At the time of the audit, a resident and family/whānau satisfaction survey was distributed. A resident meeting occurred in March 2023 for rest home and hospital level residents and residents were informed of various aspects of service delivery.</p>	<p>(i) There was no documented evidence of an annual satisfaction survey for 2022.</p> <p>(ii) There was no documented evidence of regular scheduled resident or family/whānau meetings for 2022.</p>	<p>(i)-(ii) Ensure residents, family/whānau receiving/involving in the service services are provided an opportunity to give feedback.</p> <p>90 days</p>

		Family/whānau interviewed stated they were invited to the residents meeting. Residents and family/whānau interviewed reported that they are informed about what is happening within the service through regular emails, phone calls from the clinical coordinator and registered nurses or through the three-monthly medication review and six-monthly resident review meetings.		
<p>Criterion 2.2.4</p> <p>Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them.</p>	<p>PA</p> <p>Moderate</p>	<p>There were several changes within the senior team at Mary Doyle. The clinical manager left the position in June 2022 at a similar time as the village manager. There were only two clinical coordinators left in July 2022. All five clinical coordinators have commenced employment in the last six months. The head of quality and compliance interviewed confirmed due to several changes, the implementation of the quality and risk management system has fallen behind.</p> <p>A support team from Arvida Group completed gap analysis by regular internal audits and internal review of processes to assist and support the new team at Arvida Mary Doyle. Several quality improvements and corrective action plans were documented since September 2022, related to internal reviews of processes and internal audits at Mary Doyle. Progress was regularly reviewed, but due to insufficient progress on several corrective actions plans, these have been restarted and could not be signed off.</p> <p>There was a meeting schedule documented for 2022; however, meetings were not occurring when required. There was evidence</p>	<p>(i). Several corrective action plans have been restarted due to a lack of progress and could not always be signed off.</p> <p>(ii). There was no documented evidence that clinical meetings, staff meetings, and quality improvement/IPC meetings occurred as planned for 2022.</p> <p>(iii). Staff were not always informed of regular quality data trends and analysis, outcomes of the recent staff survey or corrective actions.</p>	<p>(i). Ensure corrective actions are documented, implemented, and embedded in practice.</p> <p>(ii). Ensure meetings occur as per the meeting schedule.</p> <p>(iii). Ensure the communication and feedback is provided to staff around quality data and outcomes.</p> <p>60 days</p>

		<p>that health and safety meetings occurred as scheduled. Quality meetings were scheduled to occur bimonthly; however, there were three documented quality meeting minutes for 2022 (January, April, and October), one RN/Clinical meeting and one outbreak management meeting recorded for 2022. There was no documented evidence of staff meetings.</p> <p>There was a staff survey completed in October 2022; results were not reported to staff. Staff interviewed stated they are informed of trends/analysis/corrective actions at handover. Visual inspection of the environment evidenced quality data and trends in data were not posted on quality noticeboards for staff to see. There was no documented evidence of staff meetings for 2022. Due to limited documented evidence of staff meetings, the previous shortfall (NZS HDSS:2008 # 1.2.3.8) related to documented corrective actions raised from meeting minutes and evidence of resolution, remain an area for improvement.</p> <p>Residents and family/whānau reported that they are informed about what is happening within the service through regular emails and phone calls from the clinical coordinator and registered nurses.</p>		
<p>Criterion 2.3.3</p> <p>Service providers shall implement systems to determine and develop the competencies of health care and support workers to</p>	PA Low	<p>All staff are required to complete competency assessments as part of their orientation. Registered nurses' complete competencies, including restraint, medication competency (including controlled drug management, insulin administration and syringe driver training) and oxygen administration.</p>	Restraint competencies have fallen behind since 2022.	<p>Ensure restraint competencies are completed as scheduled.</p> <p>90 days</p>

<p>meet the needs of people equitably.</p>		<p>Additional RN specific competencies include subcutaneous fluids and interRAI assessment competency. Eight of seventeen RNs are interRAI trained. All RNs are encouraged to attend in-service training and completed critical thinking and problem solving, infection prevention and control, including Covid-19 preparedness, dementia, and delirium. All RNs attend relevant quality, staff, RN, health and safety, and infection control meetings when possible. All wellness partners and enrolled nurses are required to complete annual competencies for restraint, moving and handling, personal protective equipment (PPE), medication, handwashing, insulin administration and cultural competencies. A record of completion is maintained on an electronic register. Competencies were documented as completed for 2022. There is a competency schedule in place. Restraint competencies are completed at time of orientation; however, the annual renewal of restraint competencies has fallen behind.</p>		
<p>Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.</p>	<p>PA Low</p>	<p>All new clinical coordinators files (employed for less than six months) reviewed had a three-month appraisal completed.</p> <p>There is an appraisal policy as part of the human resource policies. An annual appraisal schedule is in place as part of a corrective action plan. The corrective action plan has been reviewed; progress has been made; however, there are still appraisals outstanding for nine staff. As the service has been working through the corrective action process, that finding has been identified as low risk.</p>	<p>The appraisal schedule has not been fully implemented.</p>	<p>Ensure the appraisal schedule is fully implemented.</p> <p>90 days</p>

<p>Criterion 3.2.1</p> <p>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.</p>	<p>PA Low</p>	<p>The service has a schedule for interRAI assessments and is working towards ensuring all assessments are undertaken in a timely manner; this is a work in progress.</p>	<p>(i)Ongoing interRAI reassessments had not always been completed within timeframes for one rest home and one dementia level resident.</p> <p>(ii)The initial interRAI assessment was not completed within timeframes for one hospital level resident.</p>	<p>(i)-(ii)Ensure interRAI assessments and reassessments are completed as per required timeframes.</p> <p>60 days</p>
<p>Criterion 3.2.5</p> <p>Planned review of a person's care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;</p> <p>(b) Include the use of a range of outcome measurements;</p> <p>(c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations;</p> <p>(d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and</p>	<p>PA Moderate</p>	<p>All resident files reviewed included a long-term care plan; however, the LTCP had not always been updated to current care needs. Registered nurse oversight is rostered for the rest home; however, a registered nurse has not always documented a regular review of care.</p>	<p>(i).Two of seven care plans reviewed had not been updated to reflect changes to resident need around mobility (hospital level) and refusal of care (rest home).</p> <p>(ii). One rest home resident returned to the service following a period in Te Whatu Ora secondary level services; there was no documented RN assessment or review of care needs for two-day post admission to the service.</p>	<p>(i)-(ii). Ensure care plans are updated to reflect current resident assessed needs.</p> <p>60 days</p>



review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.				
<p>Criterion 3.4.1</p> <p>A medication management system shall be implemented appropriate to the scope of the service.</p>	<p>PA Moderate</p>	<p>The service has robust policies in place for the safe and effective storage and administration of medications. Staff training and medication competencies are completed annually, and staff were observed administering medications safely. The controlled drug documentation did not meet required standards. Medications in the medication trolley were not all dated or within date.</p>	<p>(i)The second signature for medications given in the controlled drug book did not match the signature for the same person on the staff signature log.</p> <p>(ii)There controlled drug book documented a staff member correcting the running total. There was no documented follow up for this issue or incident form.</p> <p>(iii)One midazolam spray was out of date.</p> <p>(iv)There were creams in the medication trolley that had not been dated on opening.</p>	<p>(i)-(ii)Ensure that documentation around controlled drug management meets legislative standards.</p> <p>(iii)-(iv)Ensure medications are within date and dated on opening as needed.</p> <p>60 days</p>
<p>Criterion 3.4.6</p> <p>Service providers shall facilitate safe self-</p>	<p>PA Low</p>	<p>The staff support one resident to self-medicate insulin when out on trips. Staff were able to evidence the safe management of the insulin and processes in place to ensure the</p>	<p>(i)There was no resident assessment and sign off by the GP for self-medication as</p>	<p>(i)Ensure that self-medicating residents have all appropriate documentation including a</p>

administration of medication where appropriate.		safety of the resident, however; there was no assessment and sign off by the GP as directed by the service policies.	directed by the service policies.	GP assessment and sign off  30 days
Criterion 5.1.4 Significant IP events shall be managed using a stepwise approach to risk management and receive the appropriate level of organisational support.	PA Moderate	There is an Arvida strategic plan and Arvida Attitude of Living Well community business plan that demonstrate commitment to compliance to the IPC and AMS policies. The infection control committee, with support from the Arvida support office and IPC clinical nurse lead, provides clinical governance oversight on IPC and AMS matters at Arvida Mary Doyle. Key performance indicators in relation to IPC and AMS are monitored and benchmarked. The service had a number of Covid-19 outbreaks in 2022 and a norovirus outbreak in October 2022. There was one recorded outbreak management meeting with lessons learned debrief documented following the norovirus outbreak. No other evidence of debrief meetings /outbreak meetings were documented following the other outbreaks.	(i)There were limited documented evidence of outbreak meetings and lessons learned from outbreaks.	(i)Ensure a culture of learning is evident from significant events to promote system change and reduce risks.  60 days
Criterion 5.5.4 Service providers shall ensure there are safe and effective laundry services appropriate to the size and scope of the health and disability service that include: (a) Methods, frequency, and materials used for laundry processes;	PA Low	The facility has processes in place to manage the resident's clothing and personal items. Laundry/household staff have completed training related to their roles. Wellness partners completed IPC training as part of their orientation and annually (last completed in September 2022). IPC education includes the handling of waste and the management of cleaning and laundry. There are documented processes for the transporting/moving of dirty linen in the facility. As observed on the days of the audit, these procedures were not	The process of transporting/moving dirty linen within the facility has not been adhered to.	Ensure to review and implement the transporting/moving of dirty linen within the facility.  60 days

<p>(b) Laundry processes being monitored for effectiveness;</p> <p>(c) A clear separation between handling and storage of clean and dirty laundry;</p> <p>(d) Access to designated areas for the safe and hygienic storage of laundry equipment and chemicals. This shall be reflected in a written policy.</p>		<p>always being followed. A wellness partner was observed to carry dirty linen against their uniform and the laundry trolley had a mix of clean and dirty linen on it.</p>		
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# Specific results for criterion where a continuous improvement has been recorded

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As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

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End of the report.