

Rotorua Continuing Care Trust - The CARE Village

Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

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

The specifics of this audit included:

Legal entity:	Rotorua Continuing Care Trust	
Premises audited:	The CARE Village	
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 24 January 2018	End date: 25 January 2018
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	62	

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

The CARE Village on the shores of Lake Rotorua at Ngongotaha is run by the Rotorua Continuing Care Trust. This surveillance audit was undertaken to measure compliance with a subset of the health and disability services standards and the pilot contractual agreement.

The new model of care is based on an adapted mixed service model based on the New Zealand environment and similar to the Dutch De Hogeweyk Dementia Village concept, where people live in six to seven bedroom households and are assisted to be as independent as possible with support from The CARE Village staff. The new purpose built facility opened four months prior to the audit.

The CARE Village have been contracted to provide services for up to 81 rest home, hospital and dementia residents. At the time of the on-site audit there were 62 residents residing at The CARE Village.

The governing body consists of a trust board with four trustees. The chief executive officer is responsible for the management of the service, with the assistance of the nursing advisor.

There were 24 improvements at the previous audit, 6 have been closed out at this audit and 18 remain open, with approval of the fire evacuation scheme rated as high risk. There are eight new improvements required as a result of the current audit. Requirements for improvements relate to: communication; complaints; governance; quality and risk management systems; adverse event reporting; human resource management; service provider availability; service provision requirements; planned activities;

medicine management; nutrition and safe food services; management of waste and hazardous substances; facility specifications; cleaning and laundry services; essential, emergency and security systems; restraint management and infection control.

Consumer rights

<p>Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Staff, residents and families interviewed are able to demonstrate an understanding of the residents' rights and obligations including the complaints process. Information regarding the complaints process is available to residents and their family. The one complaint formally documented was reviewed and met the Health and Disability Commission requirements.

Family are updated in a timely manner if any changes occur in a residents' condition.

Organisational management

<p>Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The CARE Village management team includes the chief executive officer (with nursing and management experience) and the nursing advisor. The organisation's mission statement and vision is documented.

There are processes in place for incident/accident management. Adverse events are documented and discussed with residents and/or their family. The service collect data, evaluate and monitor components of clinical care and share results among staff. Professional qualifications are validated, including registration with professional bodies.

The chief executive officer understands the statutory obligations regarding essential notification.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Registered nurses assess residents on admission. Lifestyle care plans are individualised and based on a range of clinical information. Short-term care plans are in place to manage short-term problems. Residents' records reviewed demonstrated their needs, goals and outcomes are identified and reviewed at regular intervals. Handovers provide continuity of care.

The lifestyle houses have a mix of residents receiving different levels of care; including rest home, hospital and dementia care. Residents are allocated to the house that is the best fit for the lifestyle they have lived throughout their life.

Home leads are responsible for the daily running of the household and oversight of activities of daily living. The travel agent/shop manager has an activities programme in place, focussing on the social needs of residents, including community based activities. The home lead and home support staff are responsible for providing care, food, cleaning and laundry services.

The service uses an electronic medicines management system to ensure safe and appropriate prescribing, dispensing and administration of medicines. The lifestyle houses have locked boxes for the safe storage of drugs and containers for appropriate storage and dispensing of medicines. Staff members responsible for medicine management have completed annual competencies.

There is a four week, seasonal menu recently reviewed by a dietitian. Home leads confirm they follow the menus but adapt it to the specific needs or preferences of the residents. Home lead and home support staff have been provided with food safety training.

Safe and appropriate environment

<p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is a current code of compliance. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family interviewed describe the environment as appropriate with indoor and outdoor areas that meet their needs. Environmental restraint is in place for residents requiring dementia level care through wrist band technology. Residents who do not require a secure environment can exit the facility through electronic doors. Fixtures, fittings, and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

There are six to seven bedrooms per lifestyle house and the facility includes thirteen houses of which eleven were in use at the time of the audit. All bedrooms are single and use communal showers and toilets or ensuites where available.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There was one resident using an enabler and three residents' using restraints at the time of the audit. Enabler use is voluntary. Restraints are only used as a last resort when all other options have been explored. Staff interviews confirmed understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Infection surveillance is undertaken, analysed, trended and benchmarked. Results are entered into an electronic system for collation of data and benchmarking.

Surveillance records showed evidence of follow-up of infections, when required. Staff demonstrated current knowledge and practice in relation to the implementation of infection prevention and control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	5	0	3	13	1	0
Criteria	0	28	0	3	22	1	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>The organisation's complaints policy and procedures are in line with the Health & Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code) and include timeframes for responding to a complaint (refer to 1.2.3.4). The complaint forms are available at the entrance to the facility. A complaints register is in place and includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved.</p> <p>The complaints register reviewed indicated that one complaint has been received and reviewed (dated February 2017). There have been no documented complaints since the new facility opened. Evidence relating to the lodged complaint is held in the complaints folder and documented on the register. Interviews with families confirmed there is a process to complain and they had made verbal complaints which were addressed, however there was no evidence of verbal complaints being documented.</p> <p>The chief executive officer (CEO) is responsible for managing complaints. Residents and family members could describe their rights and advocacy services particularly in relation to the complaints process.</p> <p>There have been no complaints to the Health and Disability Commission or any other external authorities since the previous audit.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>PA Low</p>	<p>Information is given to residents and families on admission (refer to 1.2.1.1). The policies and procedures concerning complaints, open disclosure and accidents/incidents alert staff to their responsibility to notify family/enduring power of attorney (EPOA) of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available (refer to 1.2.3.4). Accident/incident forms evidenced family are informed if the resident has an incident/accident.</p> <p>Family contact is recorded in residents' files, however, interviews with residents and families confirmed they are not consistently kept informed regarding the change in service delivery to the mixed model of care. Interviews confirmed family and resident understanding of the concept of living in different houses based on lifestyle, however, they did not understand the mixed model of care as per service agreement clause G15.2A. Staff, residents and family interviewed stated that they did not discuss the mixed model of care with residents or their family and focused on the lifestyle model in discussions and information provided. There are monthly staff meetings, however, there was no evidence of any residents' meetings. There has not been a residents' survey since the residents moved to the new facility.</p> <p>Residents, or families/EPOA as appropriate, sign an admission agreement on entry to the service (refer to 1.2.1.1). The service accesses the Lakes District Health Board for interpreter services if required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Moderate</p>	<p>The service is managed by the CEO with nursing and management background. The CEO was the general manager of Whare Aroha CARE for approximately three years prior to becoming CEO of The CARE Village.</p> <p>There has been a change in the management structure since the last audit, with the lifestyle manager resigning in January 2018. The CEO is now assisted by the nursing advisor, the previous title was nurse manager. One registered nurse has accepted a change in their role to include administration time to assist the management team (refer to 1.2.8.1). The nursing advisor is a registered mental health nurse, who was previously employed at Whare Aroha CARE in 2011.</p> <p>The purpose, values, scope and direction of the service have been identified, however, an interview with the chairman of the board, confirmed that there is no strategic plan or quality improvement framework as per clause G19.4 a to d of the service agreement (refer to 1.2.3.1) or risk management policies to guide practice as per clause G19.3 a to d of the service agreement (refer to 1.2.3.3)</p> <p>The risk management plan, risk register and business plan do not provide details specific to the mixed model of care as per clause G19.3 a to d of the service agreement (refer to 1.2.3.1).</p> <p>The residents who transferred from Whare Aroha CARE have signed agreements pertaining to Whare Aroha CARE. The service information and agreements provided to new residents have been updated since the previous audit and residents who have entered the facility after the transition have signed agreements that have been reviewed to reflect the new model of care. However, there are aspects of the contractual requirements of the pilot service</p>

		<p>agreement which are not included (as per service information clauses G11.2 h-i & ii; and G13.3 c, g-iv, k-l, ii & iii and n).</p> <p>The CARE Village has 13 houses of which 11 are occupied. On the first day of audit, there were 25 residents at rest home level, 14 at hospital level and 23 residents requiring dementia level of care. Of these residents, there were five residents identified as younger persons with disabilities (YPD). Three of the five YPD residents were under an Accident Compensation Corporation (ACC) contract. Two of the ACC funded residents were classified hospital level and one was rest home level. The two YPD residents not under an ACC contract included one hospital level resident and one rest home level resident. The service accepts residents under a respite contract, however, at the time of the audit, there were no residents receiving respite care.</p> <p>The previous requirement for improvement for Section 31 reporting has been implemented. All remaining previous improvements remain open (refer to 1.2.3.1; 1.2.3.3).</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>The CARE Village does not have a formal documented quality improvement system (as per clause G19.4 a to d of the service agreement) and risk management framework (as per clause G19.3 a to d of the service agreement) to manage, monitor, evaluate and guide practice. Trends noted from incidents and accidents are reported to the board and in staff meetings (refer to 1.2.4.3).</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, and meet the requirements of legislation. However, the majority of the policies do not align to the mixed service model and have not been updated to reflect the contractual requirements. The document control policy is not implemented.</p> <p>Service delivery is monitored through some clinical indicators such as: complaints; surveillance of infections; pressure injuries; and falls. There is an implemented internal audit programme. The audits that have been completed since the facility opened included, for example, environmental and health and safety and housekeeping. There was no evidence provided to ascertain if clinical audits are part of the annual audit schedule and if any clinical audits have been completed to align to the mixed model and to monitor and evaluate service delivery. Where corrective actions are identified in internal audits, there is no evidence corrective action plans are developed and implemented. These are requirements for improvement.</p> <p>There is communication with all staff, through the facility's meetings. Staff meetings evidence aspects of quality improvement, risk management and clinical indicators. Staff report that they are kept informed. Copies of meeting minutes are available for review for staff unable to attend the meeting.</p> <p>The CARE Village has health and safety policies and procedures that are documented along with a hazard management programme. There is evidence that hazard identification forms are completed when a hazard is identified and that hazards are addressed and risks minimised or isolated. Health and safety is audited monthly as a</p>

		<p>component of the annual audit schedule.</p> <p>Review of documentation confirmed that YPD residents have choices, are involved in decision making, have access to technology, aids, equipment and services that are relative to their specific requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>The CEO is aware of situations in which the service is required to report and notify statutory authorities including: unexpected deaths; police attending the facility; sentinel events; infectious disease outbreaks and changes in key management roles.</p> <p>The service uses an electronic system for the documentation and review of all incidents and accidents. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events, however, there is no documented evidence of follow up or action taken as a result of events and/or accidents/incidents, to review service shortfalls, identify and manage risk. This is a requirement for improvement.</p> <p>There have been no deaths referred to the coroner or essential notifications to Ministry of Health and district health board since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Professional qualifications are validated, including registration and scope of practice, where it applies. Registered nurses annual practising certificates were sighted and confirmed during the staff and manager interviews.</p> <p>The CARE Village has an education programme. Review of the training records and interviews with staff confirmed they are supported to attend training externally and time is allocated to attend in-service training. There was no evidence to support that staff have completed dementia training unit standards on how to implement activities and therapies pertaining to the mixed service model of care (refer to 1.3.7.1). The human resource policies did not reflect the mixed service model of care (refer to 1.2.3.4).</p> <p>Interviews and documentation reviewed confirmed that all new staff are orientated to the new facility, however, there was no evidence that the mixed service model of care is included into the staff orientation programme. There is no evidence of any orientation training for the staff that transferred from Whare Aroha CARE to The CARE Village relating to the new mixed model of care. Four of the six RNs are interRAI trained.</p> <p>Staff training is recorded in the training register and staff are reminded when the mandatory training is due to be updated.</p>

		The previous requirements for improvement remain open.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Moderate</p>	<p>The CARE Village does not have a policy to provide guidelines for staffing roles and responsibilities and skill mix for the mixed model of care. Documentation supporting the new roster methodology could not be verified.</p> <p>Rosters reviewed evidenced that staff are allocated to specific houses with registered nurses (RN) covering all the houses across three shifts. There is a designated home leader for each house, who are assisted by a home support person. The job descriptions for staff do not reflect the new roles and responsibilities of staff in The CARE Village environment.</p> <p>The home leader works a morning shift and is responsible for running the house, including planning the activities of the resident's in the house (refer to 1.3.7.1), the laundry, cleaning, cooking and meeting each resident's care needs, with oversight of the RN on duty. The home support person, supports the house leader in the care of the residents and household activities. On the morning shift, there are two staff per house. On the afternoon shift there is one staff member per house with a floating home support person. Two of the houses have a home support staff member situated in the house at night. At night, the residents in the other houses are reliant on the three floater home support persons, who complete two hourly rounding's for all houses.</p> <p>Residents who are cognitively competent can choose to have duress pendants, however, not all residents have access to staff to receive timely care should it be required at night (refer to 1.4.7.5). Staff are alerted to some residents who are assessed as a falls risk through a movement sensor in the bedroom. Not all bedrooms have sensors. All staff carry phones to contact other staff if they require assistance. There is no rationale policy to guide practice to ascertain which houses require a support person situated in the house at night. Two of the four families interviewed had concerns about the night cover in the houses that did not have a staff member in the house all night.</p> <p>There is no evidence of the service having defined staffing requirements for houses with hospital level residents (as per contract G17.4).</p> <p>The previous requirements for improvement remain open.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p>	<p>PA Moderate</p>	<p>The service has a medicine and electronic medication management system in place, with an operating manual for electronic medication management processes. However, the medicines management policies and procedures do not reflect the new systems and processes implemented by the service at The CARE Village. The medicines management processes reviewed at the time of the on-site audit, complies with legislative requirements, and recorded to a level of detail that meets requirements.</p> <p>In the lifestyle houses, there are locked cupboards for residents' clinical files and medications as well as secure</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>storage areas for locking away drugs. There is one refrigerator for the storage of medicines, which is located in 'the hub' (nurses station), in the administration block, where registered nurses work from.</p> <p>Staff complete weekly checks of the medicines fridge temperatures. Review of the temperature records showed regular checks and the temperature being stable within the required range.</p> <p>Staff members responsible for medicines management complete annual competencies. At the time of the audit there were no residents who self-administered medication. Medicines management training occurs for staff. The auditors attended a lunch-time medicines round.</p> <p>The previous requirement for improvement relating to the medicines management policies and procedures not reflecting practice at The CARE Village, remains open.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>Meals are prepared on site, in each home, by the home leads. Staff files reviewed evidenced home leads had completed food safety training. Interviews with home leads and management confirmed the food is bought at the supermarket and prepared with the assistance of the home support staff and residents, as part of their activities of daily living.</p> <p>The service uses a four weekly roll-over seasonal menu which was reviewed by a dietitian at the end of 2017. Diets are modified as required and the home leads confirmed awareness of the dietary needs of residents. Residents' dietary profiles are developed on admission and identify the residents' dietary requirements and preferences. The dietary profiles are communicated to home leads on a resident's admission to the facility. Each lifestyle house is provided with a home-like kitchen including an oven, microwave, fridge, dishwasher and walk-in pantry. Regular cleaning is undertaken.</p> <p>Interviews with residents confirmed their satisfaction with food services. Family interviews indicated concerns about food services (refer to 1.1.9.1).</p> <p>The previous requirement for improvement relating to the safety of residents with dementia having free access to open plan kitchens, has been addressed and have been closed out.</p> <p>There was no evidence of specific policies and procedures to guide food services under the mixed model of care. The previous requirements for improvement relating to policy and practices including the aspects of preparation, storage, transportation, delivery and disposal of food at The CARE Village for the mixed service model, remains open; including 24/7 provision of nutritional snacks for residents who receive dementia care as per clause G15.2b of the service agreement.</p> <p>Food containers are not labelled or dated once opened and decanted. There is no records of temperature monitoring of refrigerators and freezers and are new requirements for improvement.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The residents' lifestyle care plans are completed by the RNs and based on assessed needs, desired outcomes and goals of the residents (refer to 1.3.3.3). Care planning includes specific interventions for both long-term and the short-term problems.</p> <p>The GP documentation and records are current. Staff interviews confirmed they are familiar with the needs of the residents. Family communication is recorded in progress notes (refer to 1.1.9.1). The nursing progress notes and observation charts are maintained.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Moderate</p>	<p>The previous three Whare Aroha CARE lifestyle coordinators roles (rest home, hospital and dementia level) were disestablished when The CARE Village opened. Interview with the CEO stated that activities of daily living are the activities planned for residents and, as the service reflects a home environment, there are no 'planned activities' and other activities (for example social get-togethers) are spontaneous and therefore not recorded. Interview with the nurse advisor confirmed that while residents are expected to participate in their activities of daily living, residents have choices regarding their participation in activities of daily living.</p> <p>Staff interviewed stated that the home leads are responsible for the implementation of the activities of daily living, however, they have not completed training as per clause G16.5c ii; and G17.1e of the service agreement (refer to 1.2.7.5). Job descriptions for home leads did not include activities (refer to 1.2.8.1). A newly established role (travel agent/shop manager) commenced two weeks prior to the audit. The CEO stated that this new role includes coordinating vehicles, managing the shop (which is not currently operational) and does not cover activities for residents. Interviews with the nurse advisor and the travel agent/shop manager confirmed the travel agent/shop manager role includes coordinating vehicles, managing the shop, however, both also stated that the travel agent/shop manager also coordinates activities across the site, with a focus on social activities, including outings and community based activities. The travel agent/shop manager provided a planned activities programme (reviewed) with social events and attendance records. The programme also indicated the days on which additional activities are planned for YPDs.</p> <p>There was no evidence that the travel agent/shop manager has completed training in relation to planned activities as per clause G16.5c ii and G17.1e of the service agreement (refer to 1.2.7.5) and there is no job description confirming the role of the travel agent/shop manager includes planned activities (refer to 1.2.8.1). There was no evidence to determine who is responsible for the implementation of activities, and what the processes are for implementing, monitoring and review of activities. Management presented conflicting ideas relating to activities management, There was no documented evidence of family or resident input into their activity planning as per clause 16.5e iv of the service agreement and requires an improvement. The previous requirement for improvement relating to required activities training; a documented and consent process for selection of each resident for the allocated lifestyle house, and mixed model of care policies and procedures remain open (refer to 1.1.9.1; 1.2.3.3;</p>

		1.2.8.1).
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term and the short-term care plans are evaluated in a timely manner and interRAI assessments are reviewed (refer to 1.3.3.3). The evaluations include the degree of achievement towards meeting desired goals. Residents' responses to the treatment regime are documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved.</p> <p>The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved. Short-term care plans are developed when needed and record goals and the required interventions for the identified short-term problems.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	PA Moderate	<p>The CARE Village has a dedicated area for removal of waste by a contractor. There are policies in place for waste management, however, they pertain to Whare Aroha CARE and have not been updated to reflect to the new facility and the mixed model of care. This was a previous requirement for improvement which remains open.</p> <p>Protective equipment and clothing was observed and available for staff to use when handling waste or hazardous substances. This was a previous requirement for improvement which has been closed out.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	PA Moderate	<p>The service has a current certificate of public use. This previous required improvement has been closed. The service does not have a current fire evacuation scheme (refer to 1.4.7.3).</p> <p>The lounge areas in all the houses are designed so that space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids. There are quiet areas in all houses. There are hand rails in all toilets and bathrooms. Staff confirmed that there is sufficient equipment for staff to provide care and support to residents, although equipment management policy and facility management policies and procedures were not evident or updated to reflect the CARE Village model (refer to 1.2.7.3 & 1,2,3,4).</p>

<p>for their purpose.</p>		<p>All houses have letter boxes for the residents' personal mail to be delivered including newspapers.</p> <p>All houses are situated inside the external fence perimeter which includes outdoor areas with paths, shade and gardens with areas for residents and family to meet and utilize. All residents with dementia wear wrist watches, which inactivate the automatic exit doors to the main exit and prevent dementia resident's exiting the premises unsupervised. All other residents and families can exit through the automatic doors.</p> <p>There are two houses that do not have curtains or blinds in the dining room and the corridors that face residential properties. Ensuring all rooms and corridors have a means to provide privacy for residents was a previous requirement for improvement which remains open.</p> <p>All previous requirements for improvement have been closed (refer to 1.2.3.3, 1,2,3,4 and 1.4.7.3) with the exception of privacy, which remains open.</p> <p>A test and tag programme is in place. There is evidence of some equipment having been calibrated, however, this was not consistent for all equipment. This is a new required improvement.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All rooms are single rooms and some of the rooms have shared ensuite toilets. Corridors are wide and residents could safely mobilise. There is enough space in all the bedrooms to use equipment such as hoists and wheelchairs. The previous requirement for improvement is closed.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being</p>	<p>PA Moderate</p>	<p>Cleaning and laundry equipment was sighted in all houses. There was no evidence of any policies and procedures (refer to 1.2.3.4) that reflected the mixed service model of care, or of responsibilities for staff (1.2.8.1). There were chemicals available to use, with data safety sheets provided for each chemical. Staff confirmed they had received training on the correct use of chemicals, however, chemicals were not stored securely and were observed to be sitting on shelves accessible to any resident in all houses. There was evidence of cleaning audits being completed, however are not specific to the new environment and there are no corrective actions to identify areas that required improvement (refer to 1.2.3.8).</p> <p>There was no evidence to demonstrate that the domestic laundry processes meet infection control requirements to prevent cross-infection of disease and outbreaks for residents.</p>

provided.		The previous requirements for improvements remain open.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA High	<p>A new and approved fire evacuation plan from the New Zealand Fire Service was not completed at the time of the audit for The CARE Village site. This was a previous requirement for improvement which remains open.</p> <p>Policies and procedures for the implementation of essential, emergency and security systems are not currently specific to The CARE Village (refer to 1.2.3.3). The service has not completed its first six month fire drill as they have been on the premises four months. Staff have completed fire evacuation training.</p> <p>Interviews with the CEO and the nurse advisor confirmed that residents with dementia wear wristbands which is part of a security system that activate and lock the front doors at the main entrance to the facility as soon as a resident is within a certain distance from the entrance to the facility. Interviews confirmed that there have been recent incidents relating to the wrist bands not always working. Review of the maintenance documents evidenced that this was managed and monitored at the time, however, there were no incident reports to identify these events (refer to 1.2.3.4). Movement sensors are in rooms of some residents assessed as a high falls risk.</p> <p>Residents that are cognitively sound are offered duress pendants to wear. Interviews confirmed that not all residents have or want to have a duress pendant. There was no evidence of policies and processes for assessments and consent for the use of duress pendants or room movement sensors. There was no documentation or consent to state that the resident did not want a pendant (refer to 1.1.1.9; 1.2.3.3). There was no evidence of a process to assure safety of residents without duress alarms, to call for help or assistance at any time of the day or night (particularly for residents in houses who did not have a staff member assigned at night and is reliant on the two hourly staff rounding's).</p> <p>The service has emergency equipment including a generator for emergency energy. Emergency lighting in houses is backed up with batteries and the emergency generator. There is an emergency water tank in place in case of an event. This was a previous requirement for improvement which has been closed out.</p> <p>Requirements for improvement from the previous audit, except fire training and emergency equipment/processes remain open.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	FA	<p>All areas within the lifestyle houses are ventilated and heated by a central heating system that is controlled from the administration block. All windows are double glazed to reduce noise and maintain a comfortable environment. Bathrooms and showers have vents and extraction fans. All bedrooms, communal areas and corridors have large external windows allowing natural light into the building.</p> <p>The residents who smoke have designated smoking areas and a policy is in place to support this. The service has a no smoking policy for staff when on-site and staff have been offered smoking cessation.</p>

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		The previous requirement for improvement has been closed.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	PA Moderate	<p>The service currently uses policies and procedures for infection prevention and control developed by an external provider, which do not reflect the mixed model of care.</p> <p>The infection prevention and control is coordinated by an infection control nurse (ICN) who is the nursing advisor and a registered nurse. The job description for this position is not current (refer to 1.2.8.1).</p> <p>Interview with the ICN confirmed the service does not have an infection and prevention control committee. Infection matters are presented to management and the governing body and discussed at the facility's meetings.</p> <p>The physical environmental checks of the lifestyle houses did not evidence provision of infection prevention and control measures as provided in the policies (refer to 1.4.1.1).</p> <p>Interviews confirmed staff receive orientation and ongoing education relating to infection prevention and control to minimise the risk of infections. The organisation previously collaborated with Public Health Services to produce flowcharts and notices for outbreak management, this to be updated to reflect the mixed model of care provided at The CARE Village.</p> <p>The previous requirements for improvements relating to the policies and procedures for infection prevention and control to be specific to the care at The CARE Village and the infection prevention and control manual/system having to include a facility specific infection control programme, remain open.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p>	FA	<p>The surveillance provides generic guidelines and requirements around the surveillance of infections (refer to 3.1.1). The infection logs are maintained and collated monthly by the ICN.</p> <p>Collated data is communicated to the governing board and staff. Residents' files evidenced that those residents diagnosed with an infection had short-term care plans in place. The GP interview confirmed infections are reported in a timely manner.</p> <p>In interviews, staff reported they are made aware of any infections through feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was confirmed during attendance at the handover and review of the residents' files. The ICN confirmed that there had been no outbreaks of infection at the facility since the last audit.</p>

control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Moderate</p>	<p>The review of the restraint and enabler register and interviews with management confirmed there were three residents using restraints and one resident requesting the use of an enabler at the time of audit.</p> <p>The restraint coordinator is a registered nurse. The restraint coordinator's job description was not available (refer to 1.2.8.1).</p> <p>The restraint minimisation and safe practice policy was reviewed in 2017, however, the processes do not reflect the practices of The Care Village. The previous requirement for improvement remains open.</p>

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	There is a complaints register in place identifying the one complaint lodged in February 2017. Follow up and closure was completed within the required timeframes. Interviews with families identified that two of these families had verbally complained. The families confirmed they had received feedback and resolution to the complaint, however, there was no evidence on the register documentation of the verbal complaints.	Verbal complaints are not documented on the complaints register.	<p>All complaints must be documented as stated in the organisation complaints policy.</p> <p>90 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Review of documents evidenced that families are contacted in relation to clinical changes that have impacted on their family member and stated they were informed about the lifestyle model of care. However, resident and family interviews confirmed that they were not informed of the mixed service model of care implemented in the new facility and two family members interviewed raised concern with regard to the mixed service type model of care. There was no evidence of resident meetings.	i) Seven of nine family/residents interviews stated they were not communicated with effectively regarding the changes to a mixed service model of service	i) Ensure that processes are in place to communicate with residents and families regarding changes in service delivery, including the mixed service

			<p>delivery as per service agreement clause G15.2A.</p> <p>ii) There was no evidence of resident meetings taking place.</p>	<p>model of care implemented.</p> <p>ii) Provide evidence resident meetings occur.</p> <p>60 days</p>
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	<p>PA</p> <p>Moderate</p>	<p>The strategic plan required to provide overarching guidance could not be evidenced. The business plan (2017-2018) reviewed did not provide the detail required to guide, monitor or report against at an organisational and governance level.</p> <p>Service information to residents and family and the admission agreement have been reviewed since the last audit, and is more specific to the mixed service model contract, however, not all clauses as specified in the service agreement are included in the revised documentation.</p>	<p>i) There is no strategic plan for the organisation's mixed service model of care.</p> <p>ii) The business plan is not detailed including key performance indicators, timeframes, designation of responsibilities and sign off.</p> <p>iii) The residents' information is not specific to all contractual requirements.</p> <p>iv) The admission agreement is not specific to all contractual requirements.</p>	<p>i) Develop and implement a strategic plan to reflect the mixed service model of care.</p> <p>ii) Review the business plan to include key performance indicators, timeframes, and designation of responsibilities and sign off.</p> <p>ii) Review and update the information that is given to the residents to ensure all aspects of the mixed service contract is included.</p> <p>v) Review and update the service agreement to include all the</p>

				contractual requirements. 90 days
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	<p>PA Moderate</p>	<p>There is no documented quality improvement framework required to provide overarching guidance. Quality improvement and risk policies and procedures were not evidenced.</p> <p>The risk management plan and risk register do not provide details to guide, monitor or report specific key performance indicators and is not reflective of the mixed service model of care delivery, as per clause G19.3 a to d of the service agreement. The risk management plan does not evidence key performance indicators, timeframes, designation of responsibilities and sign off. The risk register evidenced in the board report does not record whether previous risks identified have been evaluated or reported on as having been resolved and/or signed off. Mitigation strategies are not consistently documented in the risk register.</p> <p>There are process in place for internal audits to be completed, however, the audit schedule does not cover all aspects required to meet contractual requirements.</p>	<p>i) There is no formal documented quality improvement framework or policies to guide practice to meet the mixed service model contractual requirements.</p> <p>ii) The risk management plan is not supported by risk management policies, is not specific to the mixed service model, and does not document key performance indicators, timeframes, designation of responsibilities and sign off.</p> <p>iii) The risk register does not consistently document mitigation strategies or review/sign off of previous risks.</p>	<p>i) Develop and implement a quality improvement framework and policies to guide practice and meet the contractual requirements.</p> <p>ii) Develop and implement a risk management framework and policies specific to the mixed service model, and include key performance indicators, timeframes, designation of responsibilities and sign off.</p> <p>iii) Document mitigation strategies in the risk register for all risks identified and document review/sign off of previous risks.</p> <p>iv) Develop and implement an audit</p>

			iv) There are process in place for internal audits to be completed, however, the audit schedule does not cover all aspects required to meet contractual requirements.	schedule that reflects the mixed service model and aligns with contractual requirements. 90 days
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	<p>PA Moderate</p>	<p>The organisation has a suite of policies and procedures, however, they do not reflect the mixed service model and have not been updated to meet contractual requirements.</p>	<p>The policies and procedures reviewed reflected the previous Whare Aroha CARE model and do not align with the mixed service model.</p>	<p>Review and update all policies and procedures to reflect the mixed service model.</p> <p>90 days</p>
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to</p>	<p>PA Moderate</p>	<p>There is a document control policy in place, however, implementation of the policy was not evident and policies reviewed were not current.</p>	<p>The document control policy was not implemented and policy and processes were not in alignment with the current mixed service model.</p>	<p>Implement the document review policy and ensure policies are up to date pertaining to the mixed service model.</p> <p>90 days</p>

service providers and managed to preclude the use of obsolete documents.				
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Moderate	There have been four audits completed since the CARE Village opened. These audits have included housekeeping; hand washing, laundry and health and safety. There is no documented evidence to validate that there is any follow up action of the areas that were identified as requiring corrective action or if corrective actions had been reviewed and/or closed out.	There was no evidence of follow up action or corrective action plans of areas identified as requiring improvement in internal audits.	<p>Ensure that all areas identified in internal audits as requiring improvement have corrective action plans documented, implemented and signed off as completed.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Moderate	<p>All staff at The CARE Village have access to an electronic reporting system to report incidents and accidents. This system has a direct notification system to inform the managers of the event. Interviews confirmed that staff are aware of the process and actively use the system. Incidents and accidents are reported back at staff meetings and are on the meeting agendas.</p> <p>Ten of the thirteen incidents reviewed since the shift into the new service model were unwitnessed falls. The remaining three of the thirteen incidents reviewed were incidents causing harm related to aggressive behaviour between residents with dementia and either a hospital level resident or a rest home resident. There was no documented evidence of any follow up, action taken or an evaluation process to identify risk or trends associated with the mixed model of care for any of the incidents/accidents reviewed by the auditors.</p>	Thirteen of thirteen accident/incident reports reviewed had no documented follow up, action taken or an evaluation process to identify risk or trends associated with the mixed model of care.	<p>Ensure all reportable events and accident/incidents are followed up with documentation of the action taken, include an evaluation process to identify risk or trends associated with the mixed model of care and used to improve service delivery.</p> <p>90 days</p>

<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Moderate</p>	<p>The service agreement for the mixed model of care requires all staff to receive dementia unit standards qualifications to ensure staff meet all resident's needs safely in the lifestyle houses. Whilst there is evidence of in-service training being provided by the local Alzheimer's group, no documented evidence was provided demonstrating that staff are obtaining formal dementia unit standards qualifications.</p>	<p>There is no documented evidence that staff have completed or are enrolled in dementia unit standards training.</p>	<p>Evidence all staff who are working in the mixed service model are enrolled in, or have completed dementia unit standards.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Moderate</p>	<p>The orientation programme is not specific to the mixed model of care. All new staff are in the process of completing the orientation programme. Staff confirmed that there is a buddy system and staff felt supported during the orientation process. The service engages help from volunteers to assist with activities for the residents, however, safety checks (e.g. police vetting) for volunteers have not been completed in accordance with vulnerable adult legislation.</p>	<p>i) There is no evidence the mixed model is included in the orientation/induction programme.</p> <p>ii) Police vetting of volunteers was not evidenced.</p>	<p>i) Evidence the inclusion of the mixed model of care in the orientation/induction programme.</p> <p>ii) Evidence all volunteers have received police checks.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>The CARE Village has an education schedule for in-service training. The process to record staffing attendance and attendance hours was evidenced. The training programme reviewed was reflective of the previous Whare Aroha CARE service model and does not include information about the specific care needs of residents or ongoing learning as a result of the mixed model of care.</p>	<p>The training programme does not evidence care delivery or ongoing learning opportunities associated with resident care needs in the mixed model of care.</p>	<p>The staff in-service training programme should include information on specific care needs of resident's and ongoing learning as a result of the mixed model of care.</p> <p>90 days</p>

<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>The service has a staffing policy, however, it does not align to the mixed model of care, or outline roles and responsibilities for staff in the new environment. There is no staffing rationale to determine staffing requirements, cover or skill mix of the new mixed model of care. There was no documented process to identify the acuity of the mixed model of care to ensure the staff cover meets the contractual requirements of dementia and hospital level residents, in addition to rest home level residents, within the lifestyle houses.</p> <p>There are job descriptions are generic and do not have specific reference to the roles and responsibilities now associated with the mixed model of care (e.g. home leader; home support staff; RNs including the RN with recently appointed management responsibilities; travel agent/shop manager). The home leaders and home support staff have the same job descriptions.</p> <p>Interviews and records sampled confirmed the home leads are to be responsible for guiding residents in their activities of daily living within their allocated households. Interviews also confirmed that the travel agent/shop manager is responsible for planned activities. Job descriptions for the home leads and the travel agent/shop manager do not include evidence of these roles (refer to 1.3.7.1).</p>	<p>i) The staffing polices are not reflective of the current mixed service model.</p> <p>ii) Staffing rationale, including identification of acuity level of care needs for different service types within a lifestyle house (e.g. acuity of and level of care including hospital level and dementia) to determine staffing requirements are not defined.</p> <p>iii) Staff roles and responsibilities are not clearly defined in job descriptions for the mixed service model of care.</p>	<p>i) Document and implement a staffing policy that reflects the mixed model of care.</p> <p>ii) Document and implement a staffing rationale, including acuity and level of care (e.g. hospital and dementia level) to meet the needs of all residents.</p> <p>iii) Document staff roles and responsibilities in job descriptions that align with the implemented model of care at the CARE Village.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate</p>	<p>PA Moderate</p>	<p>Twelve medicines records were reviewed. Medicines management competencies were documented and are current. The electronic administration system has been reviewed and complies with legislation, protocols, and guidelines.</p> <p>The CARE Village has reference documents available for staff including the Medicines Care Guides for Residential Aged Care issued by the Ministry of Health 2015, and the Medicines Act 1981 and regulations</p>	<p>Policies and procedures for medicines management are not aligned with current practice.</p>	<p>Evidence medication management policies and procedures document alignment with the new mixed</p>

<p>prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>and guidelines for the electronic system used for administering medicines. There are medication management policies and procedures however they are not reflective of current practice, including the mixed model of care as presented in the different lifestyle settings (e.g. transportation of medication from the nurses station in 'the hub' to the houses).</p>		<p>service model and reflect current practice.</p> <p>90 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Moderate</p>	<p>There are no specific policies or procedures relating to food preparation, storage, transportation, delivery and disposal reflecting current practice at The CARE Village. Interviews confirmed cleaning schedules. Food services at lunch time was observed.</p> <p>Fridge and freezer temperatures were not monitored. Food containers were not labelled or dated once food was decanted. Evidence for provision of nutritious snacks for a 24-hour period for residents affected by dementia could not be evidenced as per clause G15.2b of the service agreement.</p>	<p>i) The policy for food services is not specific to the processes of The CARE Village.</p> <p>ii) Decanted food containers and food stored in fridges and freezers are not identified or dated.</p> <p>iii) Fridge and freezer temperatures are not monitored and recorded.</p> <p>iv) There is no evidence that residents who receive dementia care have access to nutritious snacks 24/7.</p>	<p>i) Evidence that the policy for food services includes processes specific to the services at The CARE Village.</p> <p>ii) Evidence that decanted food containers have the date of opening the original container recorded and all food stored in fridges and freezers is identified and dated.</p> <p>iii) Evidence that fridge and freezer temperatures are monitored and recorded.</p> <p>iv) Evidence that residents who require dementia care have access to</p>

				nutritious snacks 24/7. 90 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>Lifestyle care plans are in place for all residents' files reviewed. Lifestyle care plans are reviewed in a timely manner with changes reflecting the needs of the residents. Each lifestyle care plan includes opportunity for residents and or their family to sign in evidence that they contributed to the lifestyle care plan, however, none of the six residents' files reviewed, showed evidence of residents or their families contributing to the care planning process.</p> <p>InterRAI assessments are completed, however, of the six files reviewed, one did not have a recent (six monthly) interRAI update or review. Another file evidenced the interRAI assessment was completed after the lifestyle care plan was reviewed and updated.</p>	<p>i) The lifestyle care plans are not signed by the residents or their families.</p> <p>ii) The interRAI assessments are not completed within the required timeframes.</p>	<p>i) The lifestyle care plans to provide evidence of residents and or their families contributing to care planning.</p> <p>ii) The interRAI assessments to be completed within the required timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Moderate</p>	<p>Activities of daily living are considered planned activities in the mixed service model and managed by the home leads. No additional activities are considered necessary in the CARE Village model, however, interviews and document reviews provided evidence of a planned activities programme and attendance records. There was no documented evidence or planned activity roles and responsibilities for staff.</p> <p>Activities training, as per clause G16.5c ii; e; and G17.1e of the service agreement, could not be verified for the home leads or the travel agent/shop manager (refer to 1.2.7.5). There was no evidence of a documented process for ensuring the appropriate arrangements of residents sharing a house with like-minded residents, consent processes for residents and or their families as per clauses G3.1i; G4.1a, c, d, e, f; g and G15.2A a, b, c, d of the service agreement (refer to 1.1.1.9; 1.2.1.1). Policies and procedures relating to activities in the</p>	<p>i) Specific training relating to planned activities for home leads and the travel agent/shop manager could not be verified.</p> <p>ii) A documented process, and the rational for ensuring appropriate placement of residents and a consent process for this could not be</p>	<p>i) Required training relating to planned activities for home leads and the travel agent/shop manager to be completed.</p> <p>ii) A process and the rational for ensuring appropriate placement of residents and a consent process for this process to be</p>

		<p>mixed model of care as per clause G5.4 k of the service agreement (refer to 1.2.7.3) were not evident.</p> <p>Activities associated with the new mixed service model in the different lifestyle settings have not been communicated with residents and/or families (refer to 1.1.1.9).</p>	<p>verified.</p> <p>iii) Documented policies and processes to ensure planned activities are aligned with the mixed model, could not be verified.</p> <p>iv) Residents and or their family participation in planning of their activities, could not be verified.</p>	<p>documented.</p> <p>iii) Policies and processes to ensure planned activities are aligned with the mixed model.</p> <p>iv) Evidence of residents and or their family participation in planning of their activities to be recorded.</p> <p>90 days</p>
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	<p>PA</p> <p>Moderate</p>	<p>Each house was observed to have a laundry room with a domestic laundry basin. The houses do not have sluice facilities. Bodily fluids and human waste are flushed down the toilets. Urinals, bedpans or wash bowls are available for use and are cleaned using chemicals. There is currently no documented process for the management of soiled linen or clothes and there is no policy to guide practice in relation to the management of bodily fluids, human and/or infectious waste including medical waste, soiled disposable waste, wet linen, sharps or equipment cleaning specific to The CARE Village.</p>	<p>i) The service does not have policies and procedures, specific to The CARE Village, to guide practice relating to the management of waste and hazardous substances, including processes for the collecting and storage of waste.</p> <p>ii) There is no policy or processes documented providing guidelines for practice in</p>	<p>i) Develop policies and procedures for the management of waste and hazardous substances, including the collection and storage of waste, specific to The CARE Village.</p> <p>ii) Develop processes and guidelines for the sluicing and management of body fluids, human and infectious waste specific to</p>

			<p>relation to the management of body fluids and human or infectious waste for The CARE Village.</p> <p>iii) There is no policy or guidelines to guide practice for the chemical cleaning of equipment currently in practice.</p>	<p>The CARE Village.</p> <p>iii) The service to provide policy and process to guide practice for the chemical cleaning equipment.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA</p> <p>Moderate</p>	<p>Processes are implemented for the provision of newspapers, telephone use and personal mail for residents. Staff state and observation confirmed that the facility has sufficient equipment to deliver services as required by the mixed service model, however, not all equipment had evidence of having been calibrated.</p> <p>Two of the eleven occupied houses did not have curtains in the dining rooms and the corridors were visual to residential homes. The communal bathrooms and toilets are situated in these corridors.</p>	<p>i) Not all equipment was calibrated to assure safety for use with residents.</p> <p>ii) Privacy in all rooms and corridors was not evident.</p>	<p>i) Ensure a policy and procedure is implemented to ensure all equipment that is used for residents is calibrated annually.</p> <p>ii) Ensure privacy is maintained for residents.</p> <p>90 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for</p>	<p>PA</p> <p>Moderate</p>	<p>The cleaning of the houses is the responsibility of the home lead and home support staff with residents input as part of the activities of daily living.</p> <p>The laundry is completed by staff and residents in each house. There was no evidence of schedules for cleaning or monitoring of the laundry processes to align with the infection control standards.</p>	<p>i) Cleaning and laundry policies and procedures are not reflective of The CARE Village model and there was no evidence of tasks for cleaning</p>	<p>i) Evidence that all policies and procedures relating to cleaning and laundry service to be documented and updated to meet the requirements of The</p>

effectiveness.			and laundry specific to the mixed service model including cleaning schedules and processes relevant to domestic kitchens and laundries. ii) Monitoring of domestic kitchen and laundry processes to meet infection prevention requirements was not evidenced.	CARE Village, including schedules and responsibilities. ii) Evidence that all domestic cleaning and laundry procedures and monitoring processes are implemented and reviewed to meet infection prevention requirements. 180 days
Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Moderate	Each house has a domestic laundry and a domestic kitchen. Chemical data sheets are available. All chemicals are not stored securely and are accessible to all residents.	Chemicals are not stored and secured safely.	Ensure all chemicals are stored safely and securely. 30 days
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA High	There was no evidence of a current fire evacuation scheme. The audit identified that the evacuation scheme had not been completed or forwarded to the New Zealand Fire department for sign off. This was completed on the day of the audit and the audit team were informed that this would be followed up the day after the audit (email sighted to confirm this). HealthCERT were advised of the audit high risk rating.	The service does not have a current fire evacuation scheme.	Ensure the service has an approved fire evacuation scheme. 7 days
Criterion 1.4.7.5	PA	A call system is not accessible to all residents, confirmed through	i) Provide evidence	i) Provide evidence

<p>An appropriate 'call system' is available to summon assistance when required.</p>	<p>Moderate</p>	<p>resident, family and staff interviews. Residents with dementia all wear a wrist band. All residents who are assessed as cognitively intact are given the option of wearing duress pendants and room movement sensors are used for those who are assessed as a high risk of fall, however determination of who has access to any of these was not documented in either policy or procedure or in resident files through a consent process. Interviews with staff confirmed that nine of the eleven houses with residents do not have a staff member allocated at night, have two hourly rounding's (refer to 1.2.8.1). Room movement sensors are in some of these rooms and detect activity which is monitored in the nurses' station at the front of the facility. There is no policy or process to guide practice in regard to who may or may not be eligible or require alarms, movement sensors and pendants.</p>	<p>of policy, procedures and guidelines as well as the rationale for the use of motion detection sensors and pendant alarms.</p> <p>ii) Provide evidence of a process for identifying residents who may need pendant alarms.</p> <p>iii) Provide evidence of a process for residents who choose not to use pendant alarms to summon assistance.</p> <p>iv) Provide evidence of a process for ensuring that those residents who need the pendant alarms and security wristbands, will be wearing the alarms and wristbands at all times.</p> <p>v) Provide evidence of a consent process for those residents who are assessed to wear alarm/wristbands.</p>	<p>of policy, procedures and guidelines as well as the rationale for the use of motion detection sensors and pendant alarms.</p> <p>ii) Provide evidence of a process for identifying residents who may need pendant alarms.</p> <p>iii) Provide evidence of a process for residents who choose not to use pendant alarms to summon assistance.</p> <p>iv) Provide evidence of a process for ensuring that those residents who need the pendant alarms and security wristbands, will be wearing the alarms and wristbands at all time.</p> <p>v) Provide evidence of a consent process for those residents who are assessed to wear alarm/wristbands.</p>
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			vi) Not all residents have access to a call system.	vi) Demonstrate a process to enable access to a call system for all residents at anytime. 90 days
<p>Criterion 1.4.7.6</p> <p>The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.</p>	<p>PA</p> <p>Moderate</p>	<p>Residents with dementia wear wristbands which are part of a security system preventing the residents from leaving the facility. The wristbands is part of a the security system that activates and locks the main front doors as soon as this resident is within a certain distance from the door.</p> <p>Auditors could not verify policy, procedures and consent processes (refer to 1.4.7.5) for this system or how the service will ensure residents are wearing the wristbands at all times.</p>	<p>i) Provide evidence of policy, procedures and guidelines as well as the rationale for the use of security wristband and consent processes.</p> <p>ii) Provide documented evidence of how the organisation intends to ensure residents wear the wristbands at all times.</p>	<p>i) Provide evidence of policy, procedures and guidelines as well as the rationale for the use of security wristband and consent processes.</p> <p>ii) Provide documented evidence of how the organisation intends to ensure residents wear the wristbands at all times.</p> <p>90 days</p>
<p>Criterion 3.1.1</p> <p>The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control</p>	<p>PA</p> <p>Moderate</p>	<p>The organisation's infection control policies are not current and are generic policies provided by an external infection prevention and control company. Review of these policies occurred in 2017. These policies do not reflect the specific processes and procedures followed by The CARE Village in relation to its model of care. Policy, procedure or guidelines for the responsibility and accountability for infection control matters in the organisation leading to the governing body, are not specific to the practices of The CARE Village as per clause G19.2 a of</p>	<p>Policies and procedures for infection prevention and control; including guidelines for the responsibility and accountability for infection control matters in the</p>	<p>Policies and procedures for infection prevention and control; including guidelines for the responsibility and accountability for infection control matters in the</p>

<p>matters in the organisation leading to the governing body and/or senior management.</p>		<p>the service agreement.</p>	<p>organisation, leading to the governing body, are not specific to The CARE Village.</p>	<p>organisation, leading to the governing body, are to be specific to The CARE Village.</p> <p>90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	<p>PA Low</p>	<p>The infection prevention and control manual/system does not include a facility specific infection control programme. There was no evidence of an infection control programme specific to this organisation or the mixed services model sighted at the on-site audit.</p>	<p>The CARE Village have not developed a prevention and control manual/system which includes a facility specific infection control programme for its site.</p>	<p>The infection prevention and control manual/system to include a facility specific infection control programme which is reviewed annually.</p> <p>90 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	<p>PA Moderate</p>	<p>This policy was reviewed in 2017, however, it does not reflect current practice and does not refer to the mixed services model; including processes for consent and the management of environmental restraint at The CARE Village as per clause G15.3 e-i & ii of the service agreement.</p> <p>The policy does not include processes and guidelines of assessment, consent, monitoring and review of enabler and restraint use; including environmental restraint as per clause G5.4 n of the serviced agreement.</p>	<p>The policy for restraint/enabler use does not include processes and guidelines for assessment, consent, monitoring and review in relation to the mixed model, including the consent and management processes for environmental restraint, at The CARE Village.</p>	<p>The policy for restraint/enabler use to include the processes and guidelines for assessment, consent, monitoring and review in relation to the mixed model, including the consent and management processes for environmental restraint, at The CARE Village.</p>

				90 days
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

No data to display

End of the report.