

# Rotorua Continuing Care Trust - The CARE Village

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## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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: 21 June 2018 End date: 22 June 2018

**Proposed changes to current services (if any):** This audit also included verifying the service as suitable to provide medical level care under their current hospital certification.

**Total beds occupied across all premises included in the audit on the first day of the audit: 72**



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

## General overview of the audit

The CARE Village on the shores of Lake Rotorua is run by the Rotorua Continuing Care Trust. The village opened in September 2017. The new village is a pilot, under the Mixed Service Model of Care. This pilot agreement with the MOH and DHB is for a term of three years with service development oversight and termination rights.

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-seven-bedroom households and are assisted to be as independent as possible with support from The CARE Village staff. Residents live in the houses, sharing with people who have different assessed needs. Their model of care is based on creating and conserving lifestyle, independence and most importantly, community.

The village is certified to provide hospital (geriatric), rest home and dementia level care. There is a total of 81 beds across 13 houses within the village. On the day of audit there were 72 residents. This audit also included verifying the service as suitable to provide medical level care under their current hospital certification.

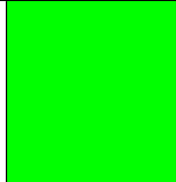
This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff, management and general practitioner.

The service is managed by a chief executive officer who has extensive nursing and management background. The CEO is supported by a village manager (RN). The management team report to the board monthly.

The organisation's goals and direction are clearly described and match the organisation's vision, values and strategies put in place to assist meeting resident needs through the Mixed Services Model of Care. Since opening, the management team have been working through a number of corrective actions from their previous partial provisional audit and surveillance audit. Considerable progress has been made around addressing these previous shortfalls.

There are two improvements required around care planning interventions and the quality programme.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |
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The CARE Village endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. The home-like care is based on providing a recognisable and familiar environment for people living in care. Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents while supporting residents to maintain their usual lifestyles. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## Organisational management

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |
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Services are planned, coordinated, and are appropriate to the needs of the residents. Business and quality goals have been documented for the service. A risk management programme is in place, which includes managing adverse events and health and safety processes.

The CARE Village has a documented quality and risk management system that supports the provision of clinical care and the mixed services model (lifestyles). A number of meetings including quality meetings are held. Quality data is collected and graphed. A resident/relative satisfaction survey has recently been completed and there are regular resident/relative newsletters.

Residents receive appropriate services that align with their model of care by suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff focused around caring for residents under the alternative model of care. Ongoing education and training for staff is in place and monitored with high attendance. Registered nursing cover is provided 24 hours a day, seven days a week. The roster is adjusted daily across the houses depending on the needs of the residents.

## Continuum of service delivery

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| 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 low risk. |
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Entry to the service is managed by the village manager/registered nurse. There is service information available on the Mixed Service model of care. Initial assessments and care plans are completed by a registered nurse. Care plans and evaluations are completed by the registered nurses within the required timeframe. Residents and family interviewed confirmed they were involved in the care planning and review process. The general practitioner reviews residents at least three monthly. There is allied health professional involvement in the care of the residents.

Residents participate in meaningful activities within the houses. The events coordinator plans the monthly group activities hosted by the houses that include community visitors, volunteers, church services and entertainers.

Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are prescribed and administered in line with appropriate guidelines and regulations.

Meals and baking are prepared and cooked in each household. The menu is varied, appropriate and reviewed by a dietitian. Individual preferences and dislikes are accommodated. There are nutritious snacks available 24-hours in each household.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |
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The main reception building has a current building warrant of fitness. There is a reactive and maintenance plan. Chemicals are stored safely throughout each household. Residents reside in houses of six to seven bedrooms. All bedrooms are single occupancy. There are communal toilet/showering facilities available in each house. There is sufficient space to allow the movement of residents around the house using mobility aids. There are lounge, dining and kitchens in each house. The outdoor areas for each house and across the village are safe and easily accessible. Home support staff in each house complete cleaning and laundry duties for the house residents. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. There is at least one staff member on duty at all times with a first aid certificate.

## Restraint minimisation and safe practice

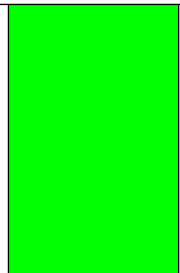
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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |
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The restraint/enabler policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures and aligns with the mixed model of care. The restraint standards are being implemented and implementation is reviewed through the clinical and quality meetings. Interviews with the staff confirm their understanding of restraints and enablers. On the day of audit, there were three residents assessed as needing restraint for safety. There were two residents with enablers.



Individual approved restraint is reviewed at least monthly through the clinical meeting and as part of restraint evaluations.

## Infection prevention and control

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| <p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p> |  | <p>Standards applicable to this service fully attained.</p> |
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training in infection control and food safety.

## 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 48                  | 0  | 2                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 99                  | 0  | 2                                    | 0  | 0                                      | 0  |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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  |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA                | <p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The Code is available in both Māori and English versions and the pamphlets and booklets are readily accessible. Staff receive training about the Code during their induction to the service, which continues through the mandatory in-service education and training programme (last completed 24 May 2018).</p> <p>Residents and families are made aware on admission that The CARE Village provides a Mixed Services Model (known as lifestyles by the staff and residents in the CARE Village). Residents are provided with care in accordance with the Code of Rights. This information is provided to residents in their admission pack and reinforced in each household.</p> <p>Interviews with staff (six home leads [senior caregivers that are responsible for each household], three home supports, three village coordinators, three registered nurses, and the events coordinators), reflected their understanding of the key principles of the Code. Home leads could describe how the Code is incorporated in their everyday delivery of care in the home-like environments.</p> |
| <p>Standard 1.1.10: Informed Consent</p>   | FA                | <p>Informed consent processes are discussed with residents and families on admission. Consent forms, advance directives and copies of enduring power of attorney (EPOA) where applicable were seen in each of the nine</p>  |

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| <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>     |           | <p>individual resident files reviewed (four rest home including one younger person under ACC funding and one respite care, two hospital level of care including one younger person under long-term chronic health condition funding and three dementia level of care residents). Residents/relatives sign general and specific consents such as influenza, the wearing of a pendant/wrist watch pendent, photographs and consent to be involved in research/pilot for mixed model of services/care.</p> <p>There is evidence of general practitioner discussion with EPOA/family regarding resuscitation where the resident is deemed incompetent to make a decision.</p> <p>Home leads, support workers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>All eight long-term residents had signed an admission agreement.</p>  |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>       | <p>FA</p> | <p>Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility and in each house. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</p>   |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | <p>FA</p> | <p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they can participate in as much as they can safely and desire to do.</p> <p>The CARE Village has been designed and built to be a part of the wider community. Since opening, they have hosted activities, performances and invited the community to share with them, and for their residents to be part of that wider community too.</p> <p>The chief executive, village manager and registered nurses are available to families as well as the individual home leads and village coordinators in this care setting. Monthly newsletters have been implemented, and all families receive a copy. Additional copies are available in all houses for residents. Family members and residents are invited to the six monthly multidisciplinary review meetings held for each resident. Family have input into the care planning and the activities programme to meet the needs of the individual resident concerned. Links are maintained with activities in the community being encouraged as part of the activities programme. Van outings into the community are encouraged. Pastoral care services are available. School</p> |

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|  |    | <p>children from the region visit the facility, volunteer entertainers provide entertainment, which is well received by the residents. A number of clubs have been established in the village. Residents are able to visit the shop within the village with their house lead to gather their supplies they need to cook their meals for the day.</p>  |
| <p>Standard 1.1.13:<br/>Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaints policy and procedures is in line with the Health &amp; Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code) and includes timeframes for responding to a complaint. 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 verbal and written complaints are captured. Six complaints have been received since the previous audit. The service proactively manages all concerns and include these on the complaint register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</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. Feedback is provided to staff on the complaints through meetings and the board is informed through monthly management reports.</p> <p>There has been one anonymous complaint to the Health and Disability Commission (HDC). There has been no follow-up required as the HDC did not consider this a complaint.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>                                | FA | <p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at the reception area to the village. The village manager, village coordinators and home leads (at each household) discuss aspects of the Code with residents and their family on admission. Six monthly multidisciplinary meetings also allow time for residents and family to discuss any concerns including individualised care and choice. The management team provide an open-door policy, and this is reflected in interview by residents and relatives. Resident meetings in each household also allows for discussions on rights. Advocacy services information is provided with the complaints procedure and complaint forms. Advocacy information is displayed at reception.</p> <p>All five residents (four rest home level and one hospital level) and seven relatives (two rest home, five dementia) interviewed, reported that the residents' rights are being upheld by the service. Interviews with staff also confirmed their understanding of the Code and its application in the Mixed Services Model. The chief executive and village manager described how they spend extra time on admission with family and residents informing them about their rights (that align with the Code of Rights) and ensuring they understand how care is</p>                             |

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|  |    | provided at The CARE Village.   |
| <p>Standard 1.1.3:<br/>Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>       | FA | <p>The CARE Village is piloting an alternative model for the provision of aged-related residential care services for people with dementia. This also covers people who are assessed as rest home and hospital level. Residents live in 6-7 room houses sharing with people who have different assessed needs. These residents live and participate in home-like environments according to their usual lifestyle. The aim is to provide a higher quality of life. Each household has house rules that support privacy, independence, dignity and respect.</p> <p>Residents interviewed confirmed they were treated with dignity and respect, privacy is ensured, and independence is encouraged. The privacy and dignity policy describes how dignity, privacy and autonomy is preserved at all times. Home leads (across the six houses) and home supports interviewed, described how they maintain independence, privacy, dignity and respect in their daily delivery of cares and support.</p> <p>There is a spiritual needs policy. Spiritual needs are identified, and church services are held every Sunday. Multi-denominational church services are also held at varying times in households with residents invites to attend from other households. Individual resident care plans include a section that identifies spiritual/cultural needs. These are completed by the RNs as part of the holistic assessment and long-term care planning process, and members of the multi-disciplinary team, can contribute to this.</p> <p>The lifestyle houses are designed to represent cultural, remote, country, minimalist, middle NZ, contemporary and classic. Part of supporting residents living normal lives is knowing their background. The service identifies that the resident's life story is an important part of who they are. This also assists the service to determine which household would the resident be best suited to.</p> <p>There is a policy on abuse and neglect and staff receive annual training which is mandatory. Household leads, and home supports interviewed had received education and had a good understanding of abuse and neglect and how to report any suspected incidences to the management team.</p> |
| <p>Standard 1.1.4:<br/>Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural,</p> | FA | <p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care and support of the resident.</p> <p>There is a Māori Health Plan 2018 – 2023. The plan reflects the Mixed Services model and meeting the needs of Māori and whānau.</p> <p>One lifestyle house identifies with Māori. For example: “the cultural house identity comes from living within a Māori cultural village setting were the marae is integral to the community and way of life. They are motivated to preserve or maintain cultural traditions and values. The home is open to many, the concept of manaakitanga</p>   |

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| <p>values and beliefs.</p>   |           | <p>being a strong value. They show respect of, and act as guardians of, the natural environment, with a spiritual connection to nature. Rituals are maintained and are an important part of everyday life (eg, “use of karakai”). There are five of six residents living in this household that identify as Māori.</p> <p>Māori consultation is available through the documented iwi links and kaumātua. The service is also supported by Lakes DHB Māori health team. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All staff interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p> <p>Values and beliefs identified during the assessment process are taken into consideration and documented on the individual resident’s care plan. All care plans reviewed were individualised to the resident and their whānau’s (family’s) needs, preferences and wishes.</p>  |
| <p>Standard 1.1.6:<br/>Recognition And Respect<br/>Of The Individual's<br/>Culture, Values, And<br/>Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>The service identifies the residents’ personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents’ care plans. All residents and relatives interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. A cultural safety policy is in place.</p> <p>Identifying resident’s values and beliefs is also reflective in the Mixed Services model of care. Each household is different, each reflecting different backgrounds residents may have lived in their life. Management, discuss each household with new residents and relatives and determine the best mix for new residents as reflected on their previous lifestyle. That is, the Middle NZ household is described as “Probably the largest representative of the community. They generally want to own their own home with a backyard. Family tends to be the cornerstone of life where it is important to find balance between traditional standards/values and change. There is community involvement with children’s interest. Most conformist and risk-averse. The traditional kiwi lifestyle”. Of the 12 households, currently five households identify as Middle NZ.</p> <p>All care plans reviewed included the resident’s social, spiritual, cultural and recreational needs.</p> <p>The CARE Village have available volunteers to meet spiritual needs of all residents and their families, regardless of their religion or faith, or residents can be referred to other spiritual care providers if required or requested. Multi denominational church services are held every Sunday afternoon in the village. Individual resident care plans include a section that identifies spiritual/cultural needs. These are completed by the RNs as part of the holistic assessment and long-term care planning process, and members of the multi-disciplinary team, can contribute to this.</p> |

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| <p>Standard 1.1.7:<br/>Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>House rules are discussed during the new employee's induction to the service and is signed by the new employee. The Mixed Model of Care has been embedded in staff policies and procedures. Policy and procedures related to discrimination ensure residents receive services free from any discrimination, and that residents are not subjected to any form of coercion, harassment, sexual or other exploitation. Professional boundaries are defined in job descriptions. Interviews with household lead, support workers, village coordinators and registered nurses confirmed their understanding of professional boundaries, including the boundaries within their roles and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>  |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>   | <p>FA</p> | <p>The CARE Village on the shores of Lake Rotorua at Ngongotaha is run by the Rotorua Continuing Care Trust. The new village opened in September 2017. The new village is a pilot, under the mixed service model of care. This pilot agreement is for a term of three years with service development oversight and termination rights.</p> <p>CARE Village was founded on the belief that there had to be a better way of delivering aged care, one which not only preserved the lifestyles of those needing care, but also challenged traditional institutional practices in the wider industry. The CARE Village is the first of its kind to be built in New Zealand. At the CARE Village, they strive to continuously challenge and better the way aged care is delivered. They have worked closely with the Ministry of Health in developing a leading-edge model with skilled staff, along with the latest in technology, meaning residents have the freedom to move about the village in a safe and constant environment.</p> <p>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-seven-bedroom households and are assisted to be as independent as possible with support from The CARE Village staff. The village currently includes a supermarket, and hairdresser. The CARE Village replicates life in the community. Interviews with staff, residents and relatives identified that the service aims to support resident to live a normal life in a way that is recognisable for them. Quality of life is the focus, residents live in households with residents from similar backgrounds, doing things that would be done in everyday life (ie, cooking, and laundry). Residents were observed completing a number of household chores and recreational activities.</p> <p>Since opening, the management team have been working through a number of corrective actions from their previous partial provisional audit and surveillance audit. Significant progress has been made around addressing these previous shortfalls. The service has been working closely with the DHB portfolio manager and the CARE Village service development group.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist's visits. Physiotherapy services are provided on-site, three hours per week. The occupational therapist position has recently become vacant with a new OT to commence soon. There is a</p> |



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|   |           | <p>regular in-service education and training programme for staff. In-service education attendance is monitored by the staff educator (RN). The service has links with the local community and encourages residents to remain independent. There are a number of volunteers that support activities and clubs within the village including (but not limited to); te reo Māori teacher, canine friends, ukulele club, historian chat-mens, knitting club, and card club.</p> <p>The service utilises technology to assist and support staffing across the village and households including (but not limited to); Wireless bed-exit monitoring system, electronic wrist watch (those assessed as requiring secure dementia level care), electronic sensor monitoring of hallways and front doors, call pendants and networked CCTV.</p> <p>The management team is focused on promoting and encouraging good practice within the mixed lifestyle model of care. All staff working in the village are supported to complete their dementia standards. Staff are educated around the Mixed Services model of Care at induction and regularly in the mandatory education programme.</p> <p>A quality and risk management system has been established.</p>   |
| <p>Standard 1.1.9:<br/>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Management interviewed described an open-door policy. Monthly newsletters are provided to residents and relatives that provides feedback on the village activities. Incident forms reviewed on the Vault electronic system identified that family were informed.</p> <p>Evidence of communication with family/whānau is documented and held in each resident's file and in progress notes. All relatives interviewed stated that they are kept well-informed when their family member's health status changes.</p> <p>A resident-centred approach to service delivery and open communication is respected by staff. A communication folder is available in each house.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents, or families/EPOA as appropriate, sign an admission agreement on entry to the service.</p> <p>Information is given to residents and families on admission, including (but not limited to) information on the Mixed Services Model and Lifestyle Policy and People living normal lives. The admission agreement has been updated to reflect the Mixed Services model of Care (lifestyle). Resident meetings have commenced in</p> |

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|   |    | households. A resident/relative survey was last completed March 2018. The results have been analysed with corrective actions established where required.  |
| <p>Standard 1.2.1:<br/>Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>The CARE Village on the shores of Lake Rotorua at Ngongotaha is run by the Rotorua Continuing Care Trust. The village opened September 2017. The new village is a pilot, under the Mixed Service Model of Care. This pilot agreement with the MOH and DHB is for a term of three years with service development oversight and termination rights.</p> <p>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-seven-bedroom households and are assisted to be as independent as possible with support from The CARE Village staff. Residents live in the houses sharing with people who have different assessed needs.</p> <p>The village is certified to provide hospital (geriatric), rest home and dementia level care. This audit also included verifying the service as suitable to provide medical level care under their current hospital certification.</p> <p>The village includes reception/administration/offices and shop and independent houses situated across spacious grounds. Thirteen of fourteen households are currently operational with 72 residents across the 81 total beds. At the time of the audit, there were 27 residents at rest home level (including three ACC funded, and one LTS-CHC), 14 at hospital level (including one ACC funded, one LTS-CHC), and 31 residents assessed as requiring dementia level of care (including one respite resident, and two Close in Age and Interest).</p> <p>The service is resident-focussed with a vision and mission statement. The organisation has a vision, which is commitment to change the model of Aged Care in NZ.</p> <p>The organisation is a Not-for-Profit Charitable Trust governed by a Board of Trustees. Business planning is undertaken at board level with input from the Chief Executive Officer (RN). The quality and risk management framework clearly identifies the organisation's roles and responsibilities and commitment to including all health care services, staffing and meeting the needs of residents and family/whānau. Both the business, risk and quality plans have recently been updated and reflect the Mixed Model of Care as per clause G19.3 a to d of the service agreement. The organisation's goals and direction are clearly described and match the organisation's vision, values and strategies put in place to assist meeting resident needs through the Mixed Services Model of Care.</p> <p>The Chief Executive Officer (CEO) reports monthly to the Board of Trustees (BOT) on all aspects of service delivery, inclusive of all quality data, risk management, occupancy and staffing (2018 monthly board meetings and reports sighted). The monthly meetings ensure that the strategic direction is being maintained. The board has commenced monitoring progress on the recently developed business and quality key performance</p> |

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|   |        | <p>indicators.</p> <p>The on-site management team is made up of the CEO and village manager (RN) who are supported by an executive assistant and administrator.</p> <p>The chief executive has an extensive nursing (previous RN, but has no current practicing certificate) and management background. The chief executive previously managed Whare Aroha CARE as the general manager for approximately three years. Prior to the role as general manager, the chief executive was self-employed, supporting health organisations in meeting the healthcare standards. The village manager (RN) has responsibility for the day-to-day management of clinical oversight. She is an experienced registered nurse with a background in mental health (including dementia level care), and aged care. The managers have completed at least eight hours annually of managing an aged care service.</p>  |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | FA     | <p>During a temporary absence of the chief executive, the village manager will provide oversight for The CARE Village.</p> <p>Since opening, the organisation has made a number of improvements to business and strategic planning documents, and policies/procedures to meet the needs of their specific ARCC agreement. Operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and promotes quality of life through the Mixed Services Model of Care.</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>                         | PA Low | <p>A quality and risk management programme has been documented. Interviews with the quality coordinator, CEO, village manager and staff from across the 12 houses reflect their understanding of the quality and risk management system and how that is implemented across the village.</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. The policies and procedures have been updated to reflect the Mixed Service Model of Care. A document control system is in place.</p> <p>Key components of the quality management system have been further established since previous audit and link to the monthly quality committee through representatives from across the service. Monthly CEO reports including feedback on quality, provide a coordinated process between service level and organisational management.</p> <p>The monthly gathering of quality and risk data includes (but is not limited to) resident falls, infection rates,</p> |

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|  |           | <p>complaints received, restraint use, and pressure injuries. An annual internal audit schedule including specific clinical-focused audits was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data is gathered, and graphs have recently been developed. The service is planning to commence benchmarking quality data between houses to identify trends. A system to monitor and close-out corrective actions have been further established with the introduction of 'audit quality cycle monthly update' document and follow-up on 'CARS' document.</p> <p>There are a number of meetings including monthly quality/IC/operations, monthly H&amp;S, monthly staff meeting and monthly clinical team meetings which includes falls prevention and restraint. The current meetings (with exception of the H&amp;S meeting) do not have agendas to ensure matters arising, key quality data and follow-through of actions required is clearly documented within meeting minutes.</p> <p>An annual resident and relative satisfaction survey has recently been completed March 2018. Results of the surveys (19% returned) identified that 100% were 'very satisfied' or 'satisfied' with living in the CARE Village. The service has followed up with corrective actions where required including developing monthly newsletters. House meetings have recently commenced in each household.</p> <p>The health and safety programme is monitored and overseen by the H&amp;S committee. There is an appointed health and safety officer who is supported by health and safety representatives from across the houses. The health and safety team meet monthly. Monthly reports from health and safety are provided to each house. The service has made a number of improvements to H&amp;S since previous audit including (but not limited to); developing house specific hazard registers. Staff undergo regular health and safety training and manual handling, which begins during their orientation. Contractors are required to be inducted into the village and sign in at reception. Actual and potential risks are identified and documented in the hazard register and risk management register. These are communicated to staff and residents as appropriate. Staff confirmed during interview that they understand and implement documented hazard identification processes. Hazards are also identified through the reporting system on Vault.</p> <p>Strategies are implemented to reduce the number of falls. This includes, (but is not limited to), physiotherapy and physiotherapy assistant input and intentional rounding. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Home leads and support workers interviewed confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p> | <p>FA</p> | <p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. These are completed on the Vault electronic incident reporting system.</p> <p>A sample of 12 accident/incident forms were reviewed across the 12 houses (May 2018). Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Incident/accident data is linked</p>   |

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| <p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>   |           | <p>to the organisation's quality and risk management programme. Incident forms that require follow-up corrective actions are reviewed by the H&amp;S person and assigned to the appropriate senior staff member to follow up and action. Shortfalls identified are used as an opportunity to improve service delivery and discussed in the health &amp; safety meeting. The service is gathering incident data under incident types, (ie, falls, behaviours). Following discussion with management it has been identified that they are planning to commence benchmarking these incidents against each house to determine trends.</p> <p>The current Vault incident register does not automatically capture incidents in relation to risk, (ie, to escalate serious incidents immediately to the village manager and CEO) (link 1.2.3.6). The service is planning to review the Vault system for effectiveness going forward.</p> <p>Interviews with the CEO and village manager confirmed awareness of their requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 completed for a resident that climbed the fence and absconded.</p>  |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eleven staff files were reviewed which included four staff who commenced since the previous audit (village manager, three RNs, one village coordinator, two home leads, three home supports and events coordinator). Some of the older files were staff that have transferred from Whare Aroha CARE and did not include all recruitment documentation. However, all newly employed staff files reviewed for the CARE Village evidenced implementation of the recruitment process, employment contracts, completed orientation, updated job descriptions, training, and competencies. A register of practising certificates is maintained.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to reflect the Mixed Services Model and the roles and responsibilities of the staff and includes documented competencies. Interviews and documentation reviewed confirmed that all new staff have been orientated to the new facility. New staff complete an orientation day, competencies are buddied for a period of time.</p> <p>A Careerforce assessor is available at The CARE Village and staff are encouraged and supported to complete qualifications. All care staff at The CARE village are required to complete the dementia standards. There are currently 37 care staff (village coordinators, home leads, home supports), 14 have completed the dementia standards, 21 are enrolled and in the process of completing, and one is a trained diversional therapist. Only one has not enrolled and advised this staff member is being managed. Staff also receive training around dementia and behaviours that challenge through Alzheimer's society.</p> <p>There is a 2018 training programme in place that is being implemented. There are a number of identified compulsory sessions. Training is repeated regularly and at various times to ensure all staff attend. A training register is monitored, and staff are followed up when they haven't attended. The Mixed Service Model in-</p> |

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|   |           | <p>service is repeated regularly at in-services. Staff also complete competencies - self tests, and a register monitors the completion of these.</p> <p>The CARE Village ensures RNs are supported to maintain their professional competency. Registered nurses are supported to attend training through the local DHB and syringe driver competencies through the Hospice. There are four of the six RNs at The CARE Village that are interRAI trained.</p>   |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>There is a staffing allocation policy, which provides the documented rationale for determining staffing levels and skill mixes for the Mixed Service Model.</p> <p>Where residents' needs for safe care require a higher level of nursing, registered nurses/village coordinators are authorised to move staff between Houses (as required), always ensuring that safe staffing levels are maintained across the village. The roster is adjusted daily with floating home support workers related to acuity levels. Adequate RN cover is provided 24 hours a day, seven days a week. The nursing structure is designed to ensure that there is an access to expert knowledge and advice at all times. The village coordinators are rostered to support the RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory. Interviews with staff that work across all shifts including night shift (six home leads, three home supports, three village coordinators, and three RNs), confirmed that staffing levels were good across all areas.</p> <p>The CEO and village manager are both RNs and work Monday – Friday.</p> <p>The following RNs are rostered across the village one RN 7.00 am – 3.30 pm (7 days a week), one RN 8.30 am – 5.00 pm (5 days a week). One RN/EN support 7.00 am -3.30 pm (4 days a week). There is one RN on an afternoon shift 3.00 pm – 11.00 pm and one RN on night shift 10.45 pm – 7.15 am.</p> <p>Each of the 12 houses has a Home lead rostered from 7.00 am – 3.30 pm Monday - Friday. There are two village coordinators rostered Saturday to Sunday. Home leads are supported by six home supports (Monday - Friday) that move between two-three houses. There are 12 home supports rostered Saturday/Sunday mornings.</p> <p>After hours (pm shift and weekends) the village coordinator, a senior care staff familiar with all houses, are assigned a group of houses to provide extra care support.</p> <p>In the afternoon shift there are 14 home supports rostered across the 12 houses.</p> <p>At night, there are three home supports rostered (with the RN) to cover the 12 houses.</p> <p>Night staff described how they move between houses to support and monitor residents. Technology assists staff to monitor those houses where staff are not stationed 24/7. Between 9.30 pm – 7.00 am the electronic sensor monitoring of hallways and front doors sends notifications to the RNs phone and nurse hub monitoring system. Staff can though go directly to that house to assist residents as able. The technology is not used to</p> |

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|  |           | <p>replace staff, it is used as a notification and allows timely monitoring and support across the village environment.</p> <p>There are 12 houses with the following service level-mix.</p> <p>House 1 (4 dementia, 2 rest home, 1 hospital resident)</p> <p>House 2 (4 dementia, 1 rest home, 1 hospital resident)</p> <p>House 3 (2 dementia, 2 rest home, 2 hospital resident)</p> <p>House 4 (6 rest home residents)</p> <p>House 5 (6 rest home residents)</p> <p>House 6 (4 dementia, 2 hospital residents)</p> <p>House 7 (4 dementia, 1 rest home resident)</p> <p>House 8 (1 dementia, 4 rest home, 1 hospital resident)</p> <p>House 9 (2 dementia, 3 rest home, 1 hospital resident)</p> <p>House 10 (5 dementia, 1 rest home resident)</p> <p>House 11 (4 dementia, 2 rest home residents)</p> <p>House 12 (6 hospital residents)</p> <p>House 14 (empty)</p> <p>There is an events coordinator rostered Monday - Friday.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | <p>FA</p> | <p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Each house has files and computers behind a closed cupboard.</p> <p>Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant staff member, allied health member, including designation.</p>   |
| <p>Standard 1.3.1: Entry To</p>  | <p>FA</p> | <p>The service has admission policies and processes in place. Residents receive a welcome pack outlining</p>   |

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| <p>Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>             |           | <p>services being provided within the mixed service model. The welcome pack includes information on dementia care and providing a safe environment within the facility of 13 individual houses. Information provided, clearly describes the lifestyle model of care. The facility village manager/registered nurse screens all potential residents prior to entry to ensure the village can meet the residents level of care supports/needs. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager. The admission agreement aligns with the requirements of the mixed services contract with the DHB/MOH. Exclusions from the service are included in the admission agreement.</p>  |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>               | <p>FA</p> | <p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>  |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses, house leads, and senior home support staff administer medications and have completed medication competencies and medication education. Medications (robotic rolls) are checked in on delivery by RNs and signed into the electronic medication system as packed in. The robotic rolls are then delivered by the RN to the individual houses (in a black portable safe) where they are stored in a locked cupboard. All other medications, pharmaceutical supplies, clinical and emergency equipment is stored safely in the RN nurses station. All 'as required' medications and impress stock (including antibiotics) were within the expiry date. The medication fridge is monitored weekly and all temperatures were within the acceptable range.</p> <p>Administration practice observed in one house was compliant against the administration policy. There were no self-medicating residents.</p> <p>Eighteen medication charts on the electronic medication system reviewed (eight rest home, four hospital and six dementia care), met prescribing requirements. Administration of medications corresponded with the medication chart. The service use standing orders and the current order has recently been updated to meet with legislative requirements and guidelines.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>  | <p>FA</p> | <p>All meals and baking are prepared and cooked within the fully functional kitchens of each house. The house leads are responsible for coordinating the menu in each house including supplying meals and baking each day.</p>  |



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| <p><b>Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>   |    | <p>There is a four-week menu that has been reviewed by the dietitian December 2017. There is flexibility around the cooking methods without altering the nutritional value or protein for the main meals (lunch and dinner). Residents are encouraged to participate in daily activities as able and desired including the cooking and baking as observed. Each resident has a nutritional screening on admission and dietary profile completed. Resident dislikes are known and accommodated. Modified meals (puree/soft) and high calorie/protein foods are provided by the house lead as relevant to their residents. House kitchens viewed were well stocked and there were nutritious snacks available 24 hours. The fridges are temperature checked (and recorded) weekly. All perishable goods and decanted goods were dated.</p> <p>There is a village shop open Monday to Friday where the house leads collect their daily supplies including meat, fresh vegetables/fruit/dry goods and snacks. Residents were observed in the shop assisting house leads, choosing their supplies and baking ingredients for their house. The events/shop coordinator (interviewed) ensures the shelves, freezers, chillers are fully stocked to meet the menu requirements. Supplies are brought in normal household amounts for dry and canned goods. All goods are rotated/replaced weekly. The chillers, fridges and freezers have temperatures checked and all goods are dated. The RNs have access to the shop after hours and weekends for any additional supplies needed.</p> <p>The events/shop coordinator and all house leads have completed food safety training.</p> <p>Residents and the family members interviewed commented positively about the quality and variety of food served.</p> |
| <p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | <p>The service records the reason for declining service entry to residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>  |
| <p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered</p>  | FA | <p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Information received from hospital discharge, homecare interRAI assessments and GP medical notes are used to develop the initial plan of care plan within 24 hours of admission. Information (including lifestyle, interests and background) gathered, assists with the appropriate house placement for the resident. Appropriate assessment tools have been completed on admission and at least six monthly or when there was a change to a resident's health condition in files sampled. Behaviour</p>   |

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| and recorded in a timely manner.  |        | assessments had been completed for the two dementia care resident files reviewed. Care plans are developed on the outcomes of these assessments. InterRAI assessments had been completed for new residents within 21 days and are utilised as part of the six-monthly evaluation of care plans.   |
| Standard 1.3.5: Planning<br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.                       | PA Low | The long-term care plans reviewed described the support required to meet the resident's goals of activities of daily living, however not all care plans had supports/needs documented to meet the resident's current health status. The care plans of two dementia care residents included behaviour management plans. The physiotherapist develops a mobility and transfer plan for all residents on admission. Allied health involvement was linked to the long-term care plans. Residents and their family/whānau confirmed they are involved in the care planning process and sign the care plan. Short-term care plans are used for changes in health status, reviewed regularly and either resolved or added to the long-term care plan as an ongoing problem. Care leads, and home support staff interviewed reported they found the plans easy to follow and readily available.   |
| Standard 1.3.6: Service Delivery/Interventions<br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA     | Registered nurses (RNs), house leads, and home support staff follow the care plans and report progress against the care requirements each shift. If a resident's health status changes the RN initiates a GP or nurse specialist review. Relatives interviewed stated they are contacted for any changes in the resident's health. Family communication records within the resident files evidence family have been notified of any changes to health.<br><br>RNs have access to sufficient medical supplies including dressings. A wound folder included wound initial assessment and treatment plans and wound evaluations were in place for nine residents with wounds. There were three residents (two hospital and one dementia care) with pressure injuries (three stage one and one stage two). Wound documentation reviewed was fully completed. RNs (interviewed) have access to nursing wound care management advice through the district nursing service or DHB wound nurse specialist. There is sufficient pressure injury prevention equipment available.<br><br>Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.<br><br>Monitoring forms are completed and reviewed, for example, monthly observations, blood sugar levels, neurological observations, weekly weights, bowel charts, pain monitoring, behaviour monitoring, wound monitoring and restraint monitoring were sighted across the files reviewed. |
| Standard 1.3.7: Planned Activities  | FA     | Each resident has a "my life" profile completed on admission and a lifestyle plan that includes individual interests and activities. The lifestyle plan is reviewed six-monthly with the MDT review. Part of the house lead   |

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| <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>role is to encourage residents to be engaged in normal household activities. The house lead maintains individual records of daily activities (household, one-on-one time, group and community activities), which is kept in the resident file (sighted). The activities are meaningful to the residents and align with their lifestyle plan. Examples sighted in files include; helping with cooking, vegetable preparation, baking morning teas, making cups of tea, folding washing, helping with daily shop for the house, caring for the home cat, and other household chores as they desire. One resident delivers the mail daily. Residents were seen to be walking throughout the village and gardens, visiting other resident houses to join in small group activities such as playing cards and knitting groups.</p> <p>The shop/events coordinator was appointed full-time January 2018, to coordinate and implement the monthly care village programme. He is a level two caregiver and is enrolled to commence the diversional therapy qualifications. The programme is displayed in the houses and the house lead ensures their residents have the opportunity to attend the events and were seen assisting residents to group activities on the days of audit. The houses are big enough to host activities/entertainers and on a nice day this can be held outside between two houses with a large outdoor area. On the day of audit, there was a singer entertaining at happy hour, which was held outside with many residents attending as observed. There are volunteers involved in the programme including (but not limited to) hairdressers, a male volunteer who meets and chats with the men and a lady volunteer takes a knitting group. Other groups include a walking group, men's shed group for under 65s, ladies' high tea and a ladies shopping group for under 65s. There are a number of regular community visitors to the village including the little villa visitors (day care children), college students, visiting chaplain, Māori cultural group and entertainers. A Māori cultural leader comes to the village weekly to teach Māori culture/te reo Māori. The houses take turns at hosting the Sunday church services. The ice-cream truck visits the facility regularly.</p> <p>The service has three vans (two with wheelchair hoist). All drivers (house leads) have current first aid certificates. Outings are planned over summer months and weather dependent in the winter, however outings are also spontaneous such as an outing to the garden centre (as seen on the day of audit). Residents are encouraged to maintain links with the community and some attend Lions club lunches and cafes. There is evidence of residents under 65 being supported to attend their former groups/clubs in the community such as arts and crafts. Many residents enjoy family outings.</p> <p>Residents and families interviewed commented positively on the activity programme. Residents have the opportunity to feedback on the activity programme through monthly resident house meetings facilitated by the house leads. The recent satisfaction survey completed identified that 90% enjoyed living with the other residents in the house.</p> |
| <p>Standard 1.3.8: Evaluation Consumers' service</p>  | <p>FA</p> | <p>All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plans have been reviewed for long-term residents who had been at the service six months or earlier for</p>   |

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| <p>delivery plans are evaluated in a comprehensive and timely manner.</p>   |           | <p>change in health. There are written multidisciplinary team reviews that include input from the GP, physiotherapist, house lead and home support staff. The resident/family are involved in the review process. There is at least a three-monthly review by the GP. Written evaluations identify if the resident/relative goals are met or unmet.</p>   |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | <p>FA</p> | <p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on the resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs and responded to in a timely manner. Referrals and options for care were discussed with the family as evidenced in medical and family communication notes. Examples of close liaison with geriatrician, dietitian, physiotherapists, podiatrist, mental health service for the older person, assessment and rehabilitation team, diabetes service ACC case worker, occupational therapist, were sighted in resident files reviewed.</p>  |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>                      | <p>FA</p> | <p>There are implemented policies in place to guide staff in waste management generally and within the houses. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff at the main chemical dispensing unit (locked room within the administration building). Home staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals bottles sighted were labelled correctly and stored safely in each house in the laundry (kiddi-locked under tub cupboard). Safety datasheets are available. Staff have completed chemical safety training.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>   | <p>FA</p> | <p>The facility (includes the 13 houses) has a current building warrant of fitness dated 23 November 2017. The maintenance person is employed full-time and has been with the Trust five years. He has a background in landscaping and is responsible for maintenance and gardens at the new facility. A maintenance book is in the RN nurses station where requests for maintenance and repairs are requested. These are addressed on a daily basis and signed off as completed. There is a planned maintenance schedule. Electrical testing and tagging has been completed November 2017, as sighted during the tour of the houses. Resident related equipment</p>  |

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| <p>environment and facilities that are fit for their purpose.</p>   |           | <p>was calibrated in March 2018 including hoists, electric beds and weigh scales. Hot water temperatures in each house in resident bathrooms are monitored monthly and records demonstrate these are maintained below 45 degrees. Essential contractors are available 24 hours.</p> <p>The individual houses are easily accessible with flat paved entrance ways and pathways between each house. Residents have access to safely designed external areas that have seating and shade.</p> <p>All the houses are located within a large village setting with a safe boundary fence. The main entrance to the facility is at the front of the administration building where rest home and hospital residents can exit and enter freely (link 1.4.7). Dementia care residents are free to wander throughout the village to the shop, visit other houses and walk along the pathways. They are monitored (by wrist watch pendent) which alerts when they are in close proximity to the main entrance. Seating and shade is provided.</p> <p>Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | <p>FA</p> | <p>All houses have communal toilet/shower facilities. Two houses have two rooms with a shared ensuite. One of the houses (number 12) with hospital level residents has a large shower room that accommodates a shower trolley that is in use for one resident. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</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 resident rooms in the houses are single and are of an appropriate size to allow rest home, dementia or hospital level of care. The rooms are individually decorated and personalised with resident belongings and adornments. There is sufficient space for the safe use and manoeuvring of mobility aids including a hoist if required.</p>   |

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| <p>Standard 1.4.5:<br/>Communal Areas For<br/>Entertainment, Recreation,<br/>And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>Each house plan, décor and furnishings are set out differently and reflects the lifestyle of the home and residents within the house. There are five Middle NZ houses, one Contemporary, one Classic, three Minimalistic, one Cultural and one Country. One house Country/Minimalistic (House 14) is not yet occupied. Each house has a dining room and lounge and a kitchen spacious enough for residents to participate in baking/cooking. The communal areas are easily and safely accessible for residents. The shop has a small library nook and tea/coffee making facilities that is accessible to residents/families. Activities can occur around the dining table or in the lounge area.</p>  |
| <p>Standard 1.4.6: Cleaning<br/>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 provided.</p>                             | FA | <p>All linen and personal clothing is done by home lead/support staff in each house. The laundry area has sufficient space to accommodate the washing machine and dryer to complete laundry duties. Each house has line drying available. Large items such as duvets/blankets are sent for commercial laundering. The laundry's also store cleaning equipment, which are secure. There is a schedule of cleaning and laundry duties sighted in the house directory. Home support staff record duties completed in the communication diary. Home support staff competing cleaning duties were observed to be wearing plastic aprons and gloves. Wet floor signs were visible, and floors mopped at a time when residents were either resting or at a group entertainment. They have access to chemicals through a mixing system. The chemical provider monitors laundry and cleaning process and there are three monthly internal audits completed. Laundry and kitchen temperatures are monitored monthly by the maintenance person.</p> <p>Residents and relatives interviewed were satisfied with the standard of cleanliness in the houses and the laundry service.</p> |
| <p>Standard 1.4.7: Essential,<br/>Emergency, And Security<br/>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>  | FA | <p>There are emergency and disaster policies to guide staff in managing emergencies and disasters. All registered nurses and house leads are first aid trained. The facility (that includes the houses) all have individual fire evacuation plans that have been approved by the fire service April 2018. The last fire drill was conducted in May 2018. Each house has fire evacuation instructions and exit signs displayed.</p> <p>There are civil defence supplies available in the event of an emergency. Each house and the administration building (including the nurses station) has emergency power backup for up to three hours including emergency lighting. There is at least three days of food items held in the shop for the village. Gas barbeques are available in the event of a power failure. There is a main water tank (25,000 litres) on-site with pump access. Staff described the process around monitoring residents in the event of a power failure which impacts on technology.</p>  |

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|  |    | <p>The CARE Village technology policy describes the technology used at the village. Residents wear pendent call bells that are linked to the call centre in the nurses' station and alarm on the portable phones carried by RNs and house leads.</p> <p>Residents at dementia level of care wear wrist watch pendants. When the resident is near the main exit doors of the village, the watch sends messages to RN/village coordinator phones and the nurses hub monitoring system. There are two automatic doors (internal and external) at the main entrance. The internal door does not open until the external door has closed and vice versa. Motion sensors in hallways and front doors at night activate the call system, which alerts home staff and RNs of any residents wandering. A wireless bed exit monitoring system is used for residents that are assessed as a high falls risk.</p> <p>The front doors of the houses are not locked at night as the whole facility is secure at night. There is a CCTV system. Cameras are installed in strategic locations across the village grounds and also strategically outside the village. These cameras are cabled back to the nurses' hub and reception monitoring system for live and historical viewing.</p> <p>Call bell response times can be monitored by management.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>The houses have central heating, which is controlled from the administration building. Windows are double glazed to retain warmth and reduce noise. There is ventilation with extractor fans in bathrooms and opening windows and doors. All bedrooms and communal areas and corridors have large external windows allowing natural light into the house. Residents and relatives interviewed confirmed satisfaction with heating and ventilation within the homes.</p>   |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and</p>  | FA | <p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control coordinator (IPC) is a registered nurse and she is responsible for infection control across the facility. The IPC committee in conjunction with the quality committee, is responsible for the development of the infection control programme and its review. The quality committee consists of a cross-section of staff and there is external input as required from general practitioners, and GPs as needed. The IC policy (reviewed March 2018) includes specific IC objectives.</p> <p>There have been no outbreaks since the opening of The CARE Village.</p>   |

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| scope of the service.  |    |   |
| <p>Standard 3.2:<br/>Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>  | FA | <p>There are adequate resources to implement the infection control programme at The CARE Village. The infection control (IPC) coordinator has completed external ICP training and she is supported by the clinical manager (CM). The infection control committee is representative of the facility and is part of the quality committee. The service subscribes to Bug Control and use their material for reference. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the homes and alcohol hand gel is freely available.</p>  |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control committee, training and education of staff and scope of the programme.</p>  |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>  | FA | <p>The IPC coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around (but not limited to) hand hygiene and standard precautions. Infection control training is part of the mandatory training programme and regularly held to ensure all staff attend at least annually (last held 26 April 2018). Staff also complete mandatory food safety training as part of their roles in the households.</p> <p>The IPC coordinator has received education through the MOH online training. The infection control coordinator</p> |



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|   |    | has access to resources, guidelines best practice through bug control.  |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>The IP policy describes and outlines the purpose and methodology for the surveillance of infections. Identifying infections (for surveillance purposes) document, provides a link to surveillance data gathered. The IPC coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service has commenced gathering data for internal benchmarking purposes across the houses to identify themes/trends.</p> <p>Effective monitoring is the responsibility of the IPC coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. There is close liaison with the general practitioners that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>A monthly report is provided to all houses in relation to IPC feedback.</p> <p>There have been no outbreaks since opening.</p>  |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>  | FA | <p>The restraint/enabler policy and procedures include the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy was updated March 2018 to reflect the mixed model and use of environmental restraint and technology. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented, and implementation is reviewed through the monthly clinical meetings. Interviews with the staff confirm their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, there were three residents assessed as needing restraint for safety. There were two residents with enablers in the form of bedrails/lap belts in wheelchairs. All enabler use was voluntary and consented. One resident file of enabler use was reviewed. The enabler consent and assessment form were completed and signed. The care plan identified the enabler use and risks were documented.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of</p>   | FA | <p>There is a 'responsibilities and accountabilities' described in the restraint policy for all key staff. The restraint coordinator is a registered nurse and has a job description. The restraint coordinator interviewed understood the role and his accountabilities. All staff complete mandatory restraint training. The process from assessment and approval is described in the policy. The restraint coordinator checks and reviews all restraint assessments. There are clear guidelines for the use of emergency restraint should these be required.</p>   |

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| <p>restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> |           |   |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>   | <p>FA</p> | <p>Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments.</p> <p>Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Files were reviewed of two residents identified as requiring restraint on the restraint register. Both files reviewed included a restraint assessment tool. The assessment identified alternatives tried and those listed in 2.2.2.1. The care plans were up-to-date and provided the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified and consents documented. InterRAI assessments identified potential risks and need for restraint.</p> <p>The policy includes an assessment process for environmental restraint. There are no residents assessed as rest home or hospital level care that requires environmental restraint.</p>  |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>   | <p>FA</p> | <p>The service has an approval process (as part of the restraint/enabler policy and procedures) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. The policy also describes potential restraints used in The CARE Village as per their mixed model of care including environmental restraint, the use of wrist watches, emergency restraint and the self-opening doors at reception. There were no residents assessed as rest home or hospital level care that requires environmental restraint and no residents currently on emergency restraint.</p> <p>The two resident files reviewed refers to specific interventions or strategies to try (as appropriate) before use of restraint. The care plans reviewed identified interventions to manage risks and monitoring. Restraint use is reviewed on implementation at the first month mark, then through three-monthly evaluations, monthly clinical meetings and six-monthly care plan reviews and multidisciplinary (MDR) meetings and includes family/whānau input. A restraint register is in place, which is currently up to date and includes the three residents requiring restraint in the form of bedrails.</p> |

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| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>   | <p>FA</p> | <p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred three monthly as part of the ongoing reassessment for the resident on the restraint register, monthly clinical meetings and six-monthly care plan reviews and multidisciplinary (MDR) meetings. The family is included as part of the MDR review. Evaluation timeframes are determined by risk levels.</p> |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | <p>FA</p> | <p>Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of restraint evaluations. Restraint monitoring is also documented in process notes, restraint log document and handovers. Restraint usage throughout the organisation is also monitored regularly through the quality meeting and through the internal auditing programme.</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)  |
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| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | PA Low            | <p>Key components of the quality management system have been further established since previous audit and link to the monthly quality committee through representatives from across the service. Minutes reviewed have been focused on corrective actions from previous external audits. As a result, meeting minutes do not reflect feedback of quality data being collected at The CARE village and follow-up of corrective actions. Quality and risk data is gathered, and graphs have recently been developed. However, the service is yet to identify trends. Incident data gathered does not identify incidents by risk/seriousness and therefore management are not alerted in a timely</p> | <p>(i) Meeting minutes did not reflect feedback of quality data and follow-up of corrective actions. (ii) The service is yet to identify incident trends and whether the mix of residents in houses impacts on trends. (iii) Incident data gathered does not identify incidents by risk/seriousness and therefore management are not alerted in a timely manner to follow up on serious incidents.</p> | <p>(i) Ensure meetings minutes identify key discussion of quality data, corrective actions and follow-up. (ii) Ensure quality data gathered, is analysed across houses to identify trends and opportunities for</p> |

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|  |        | manner to follow up on serious incidents.   |  | improvement.<br>(iii) Ensure incidents are categorised and actioned to mitigate risk.<br><br>90 days          |
| <p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | PA Low | <p>Long-term care plans identify supports for activities of daily living, cultural and spiritual values and activities. Not all long-term care plans documented interventions to support all the resident's current health needs.</p> | <p>Four long-term care plans (two rest home, one dementia care and one hospital level of care) did not include interventions to support and meet all the resident's current health status, that is, (i) there were no documented eye cares for one rest home resident as per ophthalmologist letter. The same resident was prone to urinary tract infections (UTI) and on prophylactic antibiotics, however there were no documented UTI signs/symptoms documented to support staff in reporting; (ii) the care plan of another rest home resident did not reflect de-escalation techniques to support current behaviours and a pain management plan (as per progress notes and GP notes); (iii) the care plan for one dementia care resident did not identify interventions to manage weight loss, and (iv) documented interventions for pressure injury prevention did not reflect one hospital resident's high risk of pressure injuries. The same resident did not have the current MRSA status and precautions identified in the long-term lifestyle care plan.</p> | <p>Ensure interventions are documented to support all the resident's current health needs.</p> <p>60 days</p> |

## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.