

Copper Crest Living Well Limited - Copper Crest Living Well Limited

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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 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: Copper Crest Living Well Limited

Premises audited: Copper Crest Living Well Limited

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 14 December 2021 End date: 15 December 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 32



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Copper Crest Lifecare is owned and operated by the Arvida Group. The service provides rest home, hospital, and dementia level care for up to 55 residents. On the day of the audit, there were 32 residents in total.

This certification audit was conducted against the relevant Health and Disability Services 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, staff, management, and the nurse practitioner.

There is a village manager, who has been in the role since August 2021, and has previous nursing and management experience in healthcare and age care settings. The clinical manager in the care centre is an experienced registered nurse and has been in her role since July 2021. They are supported by the national quality manager.

Residents, relatives, and the nurse practitioner interviewed all spoke positively about the care and support provided.

Copper Crest is a new facility which opened in April 2021. The facility is purpose built around the 'living well' model of care providing care for up to 11 residents in each household. There are five households in total spread across three floors of the facility.

There is an organisational quality and risk management programme documented. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This audit identified six shortfalls around implementation of the quality system, staff files, assessments and care plan interventions and monitoring.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff at Copper Crest Lifecare strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural needs are met. Policies are implemented to support residents' rights, communication, and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Copper Crest Lifecare has a current organisational business plan and a quality and risk management programme that outlines goals for the year. A meeting schedule has been developed. The internal audit schedule has been documented. Quality data is collated and benchmarked within the Arvida sites and at a national level.

Health and safety policies, systems and processes are implemented to manage risk. Falls prevention strategies are in place that includes the analysis of falls incidents.

All staff have completed a comprehensive role specific induction to the service, which includes all compulsory training and competencies.

There is an annual education and training programme in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The management team continue to recruit staff as the resident numbers increase.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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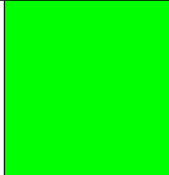
There is an admission package available that provides information on the levels of care and services available. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed in electronic resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers/wellness partners are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The wellness leader and caregivers/wellness partners coordinate and implement individual and group activities and resident led activities within each household that meets the individual recreational preferences for rest home, hospital, and dementia level of care residents.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritious snacks available 24 hours in the dementia care household.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility and each household. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. All resident rooms have full ensuites. Rooms are personalised. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. Staff have planned and implemented strategies for emergency management including Covid-19. There is always a staff member on duty with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has policies and procedures to ensure that restraint is a last resort. On the day of the audit there were no residents with any restraints or enablers. Staff have received training in restraint minimisation during the induction process.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner.

Covid-19 preparation is well documented. Policies, procedures, and the pandemic plan have been updated to include Covid-19 and continue to be updated as requirements and regulations change. There were adequate supplies of outbreak management equipment sighted. All staff and residents have been fully vaccinated. All visitors and contractors are required to complete a

wellness declaration, contact tracing requirements, and provide evidence of vaccination status in line with current Covid 19 requirements.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	41	0	3	1	0	0
Criteria	0	87	0	5	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with 12 staff (four wellness partners [caregivers], two registered nurses [RN], one wellness leader [activities], one kitchen manager, one laundry assistant, two housekeepers, and one maintenance) confirmed their familiarity with the Code. Training around the code of rights is included in the education planner and has been completed by all staff during induction to the service.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Six electronic resident files (two rest home, two hospital and two dementia level of care) contained written general consents for photographs, release of medical information and medical cares, which were included in the admission agreement (under permissions granted). These are signed as part of the admission process. Specific consent had been signed by resident/relatives for procedures such as the influenza and Covid vaccines. Discussions with care staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care.</p> <p>Enduring power of attorney (EPOA) evidence is filed in the residents' electronic charts and activated as applicable for residents assessed as incompetent to make an informed decision. The EPOA had been</p>

		<p>activated in the two dementia care files reviewed.</p> <p>Advance directives for health care including resuscitation status and medical interventions had been completed by residents deemed to be competent. Where residents were deemed incompetent to make a resuscitation decision the GP had made a medically indicated resuscitation decision. There was documented evidence of discussion with the EPOA. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</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>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy during induction and through the online education platform. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocacy support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.</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>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting now occurs by appointment only in line with the current Covid19 guidelines. Current Covid guidelines allow fully vaccinated visitors in the facility. Residents are supported to maintain links with community groups as able, pet therapy groups, church groups and entertainers visit the facility. Due to current guidelines, no school groups are able to visit. The wellness leader is currently building relationships with groups in the area.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the households. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available.</p> <p>There have been four complaints received in 2021 year to date. The complaints reviewed have been managed appropriately with acknowledgement, investigation and response recorded. Residents and relatives interviewed advised that they are aware of the complaints procedure and how to access forms. The residents interviewed felt comfortable discussing concerns with either a registered nurse or the management team.</p> <p>There have not been any complaints from external providers since the last audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service can provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the village manager or clinical manager discusses the information pack with the resident and the family/whanau. The information pack includes a copy of the Code of Health and Disability Services Consumer Rights (the Code).</p> <p>The information pack includes a copy of the Code of Health and Disability Services Consumer Rights (the Code). Interviews with seven residents (four rest home and three hospital) and five relatives (two rest home, one dementia, and two hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident, staff and quality risk/health and safety meetings.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. There is a policy that describes spiritual care. Church services are conducted regularly. All residents interviewed indicated that resident's spiritual needs are being met when required. Staff have completed training on abuse and neglect during induction. Staff interviewed could describe how they ensure privacy is maintained. Training around privacy and dignity has been completed during induction.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The organisation has established cultural policies to help meet the cultural needs of its residents. There were no residents that identified as Māori at the time of the audit. The service has established links with the DHB Runanga who are available as required. There are over 15 Iwi within the region. The Runanga provide advice on all matters pertaining to the impact of health and disability services for Māori. Arvida have contracted a cultural consultant to assist with policy review and advice.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review as demonstrated in the resident files sampled. Discussions with staff confirmed that they are aware of the need to respond to cultural differences. There is an organisational Māori Health plan which can be accessed by staff and the electronic resident management system can accommodate resident specific interventions. Cultural awareness training is completed using the online education platform during induction and is an annual topic on the education calendar.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The organisation has established cultural policies aimed at helping meet the cultural needs of its residents. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural safety/awareness. Residents and relatives interviewed felt the care plans were very individualised and catered for all individual preferences which are important to each resident. Wellness partners and the lifestyle leader interviewed described getting to know each individual residents' preferences and learning about residents' values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Arvida has an organisational staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. Residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Since the facility has opened, the management team continue to work towards recruiting staff in line with resident admissions. All staff are embracing the 'Attitude of Living Well' model of care. The facility has been built around the model of care with each household having a maximum of 11 residents. All suites are certified as dual purpose and are purchased by residents. Residents have the choice of suites available anywhere in the care centre and staffing is adjusted to meet resident's needs. The nurse practitioner and general practitioner each visit weekly. The physiotherapist visits twice a week for a total of four hours currently, and the podiatrist visits regularly. The organisation has included the required dementia standards in the Level 4 New Zealand Qualification Authority (NZQA) provided through Careerforce training. The service encourages all staff to complete NZQA qualifications. Residents interviewed are happy and culture of family within households has been well established.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs.</p> <p>Fifteen incident/accidents reviewed had documented evidence of family notification or noted if family did not wish to be informed. Interpreter services are available as required. Staff and family would be utilised</p>

		as interpreters in the first instance. There were no residents requiring an interpreter during the audit.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Copper Crest Lifecare is owned and operated by the Arvida Group. The service provides care for up to 55 residents in total (44 beds dual-purpose suites [four households of 11 suites] and 11 suites in the dementia unit). On the day of the audit there were 32 residents in total, including 19 rest home, 10 hospital and three dementia level residents. All residents were under the age-related residential care (ARRC) agreement.</p> <p>The village manager has been in the role since August 2021. The village manager is a registered nurse with a current annual practicing certificate. The village manager has previous experience in policy development, healthcare management roles and has management experience in age care settings. The village manager role includes oversight of the care centre and village. The clinical manager is a registered nurse and manages the care centre. She has been in her role since July 2021 and is on a one-year contract to cover leave. The clinical manager has previous experience of clinical management roles, acute nursing, and home care coordinator roles. They are supported by the national quality manager. The village manager has regular contact with a support partner/ mentor.</p> <p>The village manager provides a monthly report to the Arvida CEO on a variety of operational issues. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Copper Crest Lifecare has a business plan dated November 2021 and an annual quality and risk management programme.</p> <p>The village manager attends fortnightly meetings with the support partner and has attended an RVA training day. The clinical manager attends monthly Clinical Manager networking meetings.</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>In the temporary absence of the village manager, the clinical manager is in charge. Support is provided by the head of wellness operations, and the team at the support office.</p>
<p>Standard 1.2.3: Quality And</p>	PA Low	<p>There is an organisational quality and risk management system in place at Copper Crest which is</p>

<p>Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>designed to monitor contractual and standards compliance. There is a 2021 business/strategic plan that includes quality goals and risk management plans for Copper Crest. The village manager and clinical manager are responsible for providing oversight of the quality and risk management system on site, which is also monitored at organisational level.</p> <p>Arvida Group policies are reviewed at least every two years across the group.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been documented however, not all audits have been completed as scheduled. Areas of non-compliance are identified through quality activities and are actioned for improvement. Corrective actions identified as moderate or high levels, are entered into the corrective action log and folder is maintained to document progress towards completion. Corrective actions are graded as low, moderate, or high. Not all action plans show evidence of sign off completion. A quality report is provided by the support office and sent to each facility with benchmarking data.</p> <p>There are weekly management (head of departments) meetings held to ensure all departments are informed of topical information. The village manager is in the process of developing an agenda for a quality/ staff meeting, which will include quality data, restraint/enabler use (if used) and infection control. Staff meetings are currently held monthly and discuss a range of topics; however meeting minutes do not document discussions around quality data, benchmarking, and corrective actions.</p> <p>The service has a health and safety management system that is regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee (representative of the facility) at the monthly meeting. There are also monthly national health and safety meetings conducted online through Teams meetings. The village manager and clinical manager are part of the health and safety committee. Hazard identification forms and an up-to-date hazard register is in place through the Mango system. The health and safety representative (laundry assistant) interviewed has developed a folder for each household containing hazard forms, staff injury forms, early warning signs of injury. Training has been booked to provide manual handling training for non-clinical staff.</p> <p>Falls prevention strategies are implemented including identifying residents at higher risk of falling and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention strategies include (but are not limited to); the use of low beds, call bell pendants and bracelets, landing mats and bed sensors to alert staff of when residents are out of bed during the night.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at shift handovers. An RN conducts clinical follow-up of residents.</p>

<p>untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Incident forms reviewed for October and November 2021 demonstrated that appropriate clinical follow up and investigation occurred following incidents and family notifications were documented. Neurological observation forms were not always fully completed as per policy for unwitnessed falls or potential head injuries (link 1.3.6.1).</p> <p>Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Notifications were sent from the support office for the change of management and no other notifications have been required. There have been no outbreaks since opening in April 2021.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience, and veracity, however not all job descriptions were evident in staff files.</p> <p>Eight staff files were reviewed (one clinical manager, one RN, two wellness partners, one wellness leader, one housekeeper, one kitchen hand/ barista, and one kitchen manager). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were not yet due as staff not yet been employed for a year; however, appraisals have been completed post induction. A copy of practising certificates is kept.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme. The orientation programme is completed in stages. All employees complete a core induction to orientate to code of rights health and safety, prevention of workplace injuries, infection control, fire safety, communication, and a village tour. Part two is role specific, which includes all education and completion of relevant competencies and the final part is a post induction performance review.</p> <p>The in-service education programme for 2021 is being implemented. The education programme has been aligned to fit the 'attitude of living well' model of care and themes for the month. Discussions with the wellness partners and RNs confirmed that Altura online training is available and implemented by staff. More than eight hours of staff development or in-service education has been provided annually.</p> <p>There are six RNs at Copper Crest and five have completed interRAI training. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the DHB. All staff are encouraged to complete New Zealand Qualification Authority (NZQA) through Careerforce. There are 20 wellness partners in total; two have achieved level 2, three have completed level 3 and, and 10 have achieved level 4 NZQA qualifications in Health and Wellbeing.</p> <p>Competencies completed by staff included medication, insulin, wound care, manual handling, hand</p>

		hygiene, syringe driver and restraint with an up-to-date register maintained.
<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>	FA	<p>Copper Crest has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The service has a total of 52 staff in various roles across the village. Staffing rosters were sighted and there is staff on duty to meet the resident needs. Policies are in and staffing ratios are in place around recruitment as resident admissions to the service increase. The village manager and clinical manager work 40 hours per week and are available on call after-hours for any operational and clinical concerns respectively. There is at least one RN on duty at all times. The RN coordinator on each shift is aware that extra staff can be called on for increased resident requirements. Two registered nurses are rostered on Tuesday and Wednesday for documentation.</p> <p>There are dedicated housekeeping and laundry staff. Interviews with staff and residents confirmed there are sufficient staff to meet the needs of residents.</p> <p>Each household has 11 suites.</p> <p>Household 1 (dementia) currently has three residents. Staff work 12 hour shifts from 7am – 7.15pm and 7pm to 7.15am to provide consistency.</p> <p>Each shift has an RN coordinator who assesses the acuity of residents and determines where assistance is required for the remaining four households. Night shifts are covered with one registered nurse and three wellness partners (one on each floor) from 11pm to 7.15am. Residents at risk of falling have sensor pads in their beds to alert staff.</p> <p>Household 2 is situated on the ground floor and currently seven rest home residents have one wellness partner across all shifts; 7am to 3.15pm, 3pm to 11pm.</p> <p>Household 3 (five hospital and three rest home) and household 4 (three hospital and four rest home) are situated on level 1 and have 11 suites each. There are three wellness partners on morning and afternoon shifts.</p> <p>Household 5 is situated on level 2 and has two hospital and five rest home residents. There is one wellness partner on morning and afternoon shifts.</p> <p>A 'float' wellness partner is available to assist as required between the floors.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	FA	<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. Residents' electronic files are protected from unauthorised access by individual passwords. Other residents or</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>members of the public cannot view sensitive resident information. Entries in records are legible, dated and electronically signed with designation by the relevant staff member entering the information in the electronic system.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. There are admission information packs on the rest home services for long-term rest home, hospital and dementia level of care which are provided for families and residents prior to admission or on entry to the service. The clinical manager screens all admissions to ensure the residents needs can be met. All permanent residents require a written approval for rest home level of care prior to admission. All six long term admission agreements were signed and aligned with contractual requirements. Residents and/or their EPOA also sign an Occupancy Rights 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>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service. Each resident file has an electronic record of admission and transfers.</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>There are policies and procedures in place for safe medicine management. Medications are stored safely in a medication room located in each dual-purpose household and the dementia care household. Each ensuite has a locked cupboard where the residents' medications are stored. Registered nurses and senior caregivers/wellness partners complete annual competencies and medication education. Regular and 'as required' medications are delivered in robotic rolls. The nightshift RN check the packs against the electronic medication chart and medication reconciliation is recorded in the electronic medication system. Any discrepancies are fed back to the supplying pharmacy.</p> <p>There was one rest home resident self-medicating who had a self-medication competency completed. An impress supply stock is held in household 3 and checked regularly for stock levels and expiry dates. The medication fridge temperatures and medication room air temperatures are checked daily and recorded. Temperatures had been maintained within the acceptable temperature range. Eye drops were dated on opening.</p> <p>Twelve electronic medication charts were reviewed (four rest home, four hospital and four dementia care) and met prescribing requirements. Medication charts had photo identification and allergy status notified. The GP/NP had reviewed the medication charts three-monthly. 'As required' medications had prescribed</p>

		indications for use. Caregivers/wellness partners administering medications in the dementia household require RN authorization for the administration of as required medications (link 1.3.6.1).
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals and baking are prepared and cooked on site. There is also an on-site café. The kitchen manager/chef oversees food services and works Wednesday to Saturday 6.30am – 5pm. He is supported by a part-time chef, cook and café assistants. All food services staff have completed food safety training. The Arvida four weekly seasonal menu is reviewed by the group registered dietitian. There are two menu choices for the midday and evening meal. There are weekly cooked breakfasts on Saturdays. Daily menus are displayed.</p> <p>The kitchen is located in the basement service area and food is delivered in scan boxes to the household kitchens for serving. The kitchen manager receives dietary profiles for each resident and notified of any dietary changes/requirements. Dislikes and special dietary requirements are accommodated including food allergies, diabetic options, and gluten free. The service uses pure foods for pureed/soft meals as required. There are nutritious snacks delivered daily and available 24 hours in the dementia care household.</p> <p>The food control plan was issued June 2021 and is current. Daily temperature checks are recorded for freezer, fridge, chiller, inward goods, end-cooked foods, cooling, and reheating (as required), dishwasher rinse and wash temperatures. All perishable foods and dry goods were date labelled. Cleaning schedules are maintained. Staff were observed to be wearing appropriate personal protective clothing. Chemicals were stored safely. Chemical use and dishwasher efficiency is monitored by the chemical provider monthly.</p> <p>Residents provide verbal feedback on the meals through the household meetings. The chef does walkarounds chatting to residents and gathering feedback on the meals. Residents and relatives interviewed were satisfied with the meals provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Low</p>	<p>The RN completes an admission assessment including relevant risk assessment tools; however behaviour assessments had not been completed for two residents with known behaviours of concern and a pain assessment had not been completed for one resident on return from hospital. InterRAI assessments and long-term care plans were completed within the required timeframes for the six resident files reviewed. The outcomes of assessments completed were reflected in the needs and supports documented in the care plans on the electronic eCase system. Other available information such as discharge summaries, medical and allied health notes, and consultation with resident/relative or significant others form the basis of the long-term care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Resident care plans on the electronic system for all resident files reviewed were resident-focused and individualised. Support needs as assessed were included in the long-term care plans. The eCase programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks, daily activities of living, transferring and mobility, nutritional, behaviour support plans (link 1.3.4.2), cultural and pastoral plans, and leisure plans. Care plans were current and are updated with any changes to care or health status (link 1.3.6.1).</p> <p>Care plans include the involvement of allied health professionals involved in the care of residents in meeting their specific goals around wellbeing. Residents/relatives interviewed confirmed they were involved in the development and evaluation of the long-term care plan. There was documented evidence of family involvement in the development of care plans.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including podiatrist, dietitian, speech language therapist, services for the older person including mental health services.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Residents and relatives interviewed reported their needs and expectations were being met. When a resident's condition alters, the registered nurse initiates a review and if required a GP/NP visit or nurse specialist consultant. There was documented evidence in the progress notes of family contact for all changes to health including infections, accident/incidents, GP visit, medication changes and any changes to health status.</p> <p>Wound assessments, wound management plans with body map, photos, and evaluations for seven wounds including three pressure injuries were reviewed on eCase. Wound assessments had not been fully completed or sizes for two hospital residents with pressure injuries. One hospital resident had a community acquired stage 3 pressure injury and one stage 2 facility acquired pressure injury and another hospital resident had a facility acquired stage 2 pressure injury. There is access to a wound nurse</p>

		<p>specialist.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. There is access to a continence specialist as required.</p> <p>Care plans reflect the required health monitoring interventions for individual residents however not all monitoring was implemented as required. Caregivers/wellness partners and RNs complete electronic monitoring charts including personal cares, bowel chart, blood pressure, weight, food and fluid chart, behaviour chart, blood sugar levels, repositioning chart, urinary output charts and toileting regime. Progress notes record resident wellbeing status however there were no outcomes documented (in medication system) for the effectiveness of analgesia administered. Neurological observations had been completed for unwitnessed falls.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a wellness leader who is a qualified counsellor and has a background of leadership in mental health services, DHB and Ministry of Social Development. Her role is to work alongside caregivers/wellness partners in the households to them to participate in and encourage resident led activities and provide the resources to achieve their recreational goals. Activities also take place in small groups or one on one activities.</p> <p>The wellness leaders take daily visits to each household and the wellness partners visit residents in rooms daily. Some activities are set however the programme allows for flexibility and resident choice of activity. There are planned activities for larger groups, integrated activities, and outings. Household activities include quizzes, exercises, baking, knitting, crafts, and music. There is a movie theatre in the facility. Weekly church services are taken by a minister from the village. Festive occasions and theme days/events are celebrated. Community events/outings have been affected by Covid restrictions. Independent residents are encouraged to attend village events in the Meridian Centre.</p> <p>Wellness Partners bring along their therapy dogs, farm animals and there are three household cats.</p> <p>Residents in the dementia care household were observed to be involved in individual activities such as newspaper reading and hand therapy, games, and puzzles. There is free access to gardening activities.</p> <p>A resident activity assessment and leisure profile is completed soon after admission. Individual leisure plans were seen in resident electronic files reviewed. Leisure plans are evaluated six-monthly and align with the care plan reviews. The service receives feedback and suggestions for the programme through household meetings which are open to families to attend. The residents and relatives interviewed were happy with the variety of activities provided.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All interim care plans for long-term residents were evaluated by the RN within three weeks of admission in consultation with the resident/relative. Long-term care plans have been evaluated by the RN six monthly for residents who had been at the service six months. Long-term care plans had been updated with any changes to health status following consultation with the resident (as appropriate), relative, physiotherapist, GP/NP, care staff and any other health professional involved in the resident care. Written evaluations and family conversations had been recorded in the progress notes and identified if the resident goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Ongoing RN evaluations occur as indicated and are documented within the electronic progress notes.</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 to other health and disability services is evident in the resident files reviewed. Referral documentation is maintained on resident files. Discussion with the clinical manager identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</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 documented processes for waste management. There are secure sluice rooms (with sanitiser) in each household. Chemicals are stored safely within the cleaners' cupboards. MSDS for chemical products are available and personal protective equipment is readily available. Relevant staff have completed chemical safety training. Staff were observed to be wearing these as they carried out their duties on the day of audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible</p>	<p>FA</p>	<p>The building has been open less than one year. There is a current building warrant of fitness that expires 1 August 2022. There are four 11-bed dual purpose households and one 11 bed dementia care household cross three levels with lift and stair access.</p> <p>There is a full-time maintenance person employed who oversees maintenance for the village and care</p>

<p>physical environment and facilities that are fit for their purpose.</p>		<p>centre. He is assisted by a part-time maintenance person and gardening team. There is a log sheet at the main entrance for reporting maintenance and repairs. Essential contractors are available 24 hours. The building and all equipment are still under warranty. A planned maintenance schedule is being developed to commence in March 2022. Random monthly hot water temperatures are being monitored and are within the acceptable range. Clinical equipment has been calibrated. Care staff interviewed state there is sufficient equipment to carry out the cares as per the care plans.</p> <p>The communal areas in each household can be safely accessed with the use of mobility aids. Each household is designed as a small stand-alone household which is very home-like. There are spacious outdoor areas off the communal lounge on ground level and lower ground level. The service has available shade, seating, tables, and chairs.</p> <p>The dementia household is on the ground level. Entry and exit to the household are secure. All rooms and communal areas allow for safe wandering and safe use of mobility equipment. There is access to a secure outdoor landscaped garden, circular walking track with seating, shade and raised gardens. A sensory garden has been developed.</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>Every resident's room has an ensuite with an accessible shower, toilet, and hand basin. There is one communal toilet with privacy lock near the open plan communal lounge and dining room in each household.</p> <p>In the dementia household, coloured toilet seats make an easier contrast for residents with dementia. There are also well-placed communal toilets near the communal lounge and dining room. Communal toilets are well signed.</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>Dual-purpose households: Residents rooms on the ground floor, level one and level two hospital/rest home are spacious and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. The rooms viewed were personalised with furnishings and adornments. Ceiling hoists are available in the resident rooms.</p> <p>Dementia household: Residents rooms in the dementia household are spacious and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Rooms occupied were personalised.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each of the four 11-bed dual-purpose households have an open-plan dining area, kitchen and lounge area that suits the number of residents living in that household. Each household also has a sunroom lounge at the end of the hall. The communal lounge/dining room has suitable furnishings and seating placed to provide a homely environment and accommodate individual or group activities. There is also a large communal lounge on the lower floor beside the café that can be used for large group activities and entertainers. There is access to the movie theatre and hairdresser.</p> <p>Dementia household: The dementia household is a similar design to the dual-purpose floors above. The open-plan living area, dining area and kitchen is spacious and suitable for 11 residents. The open plan area allows for individual and group activities and free access to the outdoor gardens.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The organisation provides housekeeping and laundry policies and procedures to ensure all cleaning and laundry services are always maintained and functional. The laundry is in the service area on the lower ground level. There is a laundry worker on duty seven days a week from 6.30am to 3.30pm. There is a clean and dirty separate entrance and defined clean/dirty areas within the laundry. The laundry has commercial washing machines and dryers and a smaller washing machine for delicates. Dirty linen is sorted in the household and delivered to the laundry via the secure laundry chutes in each household. There is separate folding and linen store room. There is a service lift to transport clean linen to each floor. There was sufficient linen sighted in the households.</p> <p>The housekeeping team work from 8am – 4pm seven days a week. There are locked cleaners' cupboards on each floor where chemicals are also stored. Safety data sheets are available. Housekeeping trolleys are well equipped and stored in the locked cleaning when not in use. Staff have completed chemical safety training and infection control education including Covid outbreak management.</p> <p>The organisation has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as part of the quality programme. The chemical provider monitors the effectiveness and use of chemicals.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	FA	<p>There is an emergency and evacuation procedures and responsibilities plan in place. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service in February 2021 for the new building. A fire evacuation drill was last held in September 2021. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments.</p> <p>There are adequate supplies in the event of a civil defence emergency including emergency power back</p>

situations.		<p>up, civil defence and first aid kits, food, water (large water tanks), blankets and gas cooking (gas hobs). There are also sufficient supplies of outbreak/pandemic and personal protection equipment (PPE) available. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is rostered in each shift.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas which are linked to cell phones. There are security procedures in place.</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>Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. Resident room temperatures can be adjusted in all rooms. There is overhead cooling and heating system in all rooms and communal areas and underfloor heating in bathrooms. All rooms have large windows and or balconies. Some dementia rooms on the ground floor have access to the gardens.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The clinical manager is the designated infection control coordinator with a job description on file. The organisational infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The organisational infection control plan is reviewed on an annual basis. It is linked into the quality management system (link 1.2.3.6). the clinical manager and village manager are reviewing the meeting schedule and are considering combining a quality/ infection control and staff meeting to ensure all staff are aware of all quality data results, benchmarking and corrective actions required. The outbreak management internal audit identified no corrective actions in October 2021.</p> <p>Signage is in place to remind visitors not to visit if they are unwell. All visitors and contractors are required to sign in at reception, scan QR codes, complete wellness declarations and provide evidence of vaccine status. Appointments are made for visiting at present in line with current Covid restrictions. Hand sanitiser is available at the main entrance and throughout the facility. Adequate supplies of personal protective equipment were sighted.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information</p>	FA	<p>The designated infection control coordinator has been in the role since July 2021. The infection control coordinator has access to expertise within the organisation, local laboratory, DHB infection control team, public health team, and the GPs. There are adequate resources to implement the infection control programme for the size and complexity of the organisation.</p>

resources to implement the infection control programme and meet the needs of the organisation.		There is a Covid-19 resource folder and pandemic/outbreak cupboard with sufficient personal protective clothing and hand sanitisers. Isolation kits and foot pedal bins are set up ready for use in isolation rooms. There were weekly virtual Teams meetings with Arvida support office and a consultant virologist during lockdown providing a forum for discussion and support for facilities. Screening logs were maintained for staff during the lockdown levels. Staff were in designated 'bubbles' for each household during the last level 4 Covid19 lockdown.
Standard 3.3: Policies and procedures 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.	FA	Arvida group infection control policies and procedures meet best practice. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Policies and procedures are reviewed at support office in consultation with infection control coordinators. Policies are available on the intranet. Policies and the pandemic plans have been updated to include Covid-19.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. All staff complete infection control education on the Altura system. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records. Training around Covid19, donning and doffing personal protective equipment and infection control and handwashing are included in the induction package, and ongoing education throughout the year on the Altura system.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities,	FA	Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the infection register on the electronic data base. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. The service receives benchmarking feedback from support office. This data is monitored and

<p>and methods that have been specified in the infection control programme.</p>		<p>analysed for trends monthly, however, infection control surveillance data was not evidenced as discussed with staff (link 1.2.3.6). Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. On the day of the audit there were no residents using restraint or enablers. Staff receive training on restraint minimisation and enabler use.</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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	A range of meetings are held currently including weekly management meetings, monthly staff meetings and monthly health and safety meetings. The village manager is currently reviewing the meeting structure to include a combined staff/ quality and infection control meeting. Quality data reports are provided each month by the support team at head office and sent to each facility to include benchmarking, however, current meeting minutes do not evidence discussion around this data, benchmarking, internal audits, and corrective actions with staff.	Minutes of meetings held do not evidence discussion around quality data collated internal audits and corrective actions (where identified) with staff.	Ensure meeting minutes document discussion around quality data and corrective actions with staff. 90 days
Criterion 1.2.3.7 A process to measure achievement	PA Low	An organisational internal audit schedule is documented, however not all internal audits have been completed as scheduled.	Internal audits not completed include medication management, interRAI, behaviours tracer, controlled medications, staff induction, and	Ensure all internal audits are completed as scheduled.

against the quality and risk management plan is implemented.			complaint management.	90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	The internal audit documents indicate corrective actions identified. Corrective actions are graded to low, medium, and high levels using a matrix at the end of each internal audit. A corrective action folder has been developed where corrective actions are logged for medium level corrective actions. High level corrective actions are reported to the support office. Low level corrective actions are documented at the end of the internal audit form and are signed by the clinical manager (who completes the audits) however, these are not signed off on completion of the actions.	Corrective actions were not signed off as completed and discussed at meetings for falls management, wound management, medications, interRAI assessments, staff files, pain management tracer and the medication audit.	Ensure corrective actions are signed off when completed. 90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	A review of eight staff files selected at random evidenced employment procedures were being followed, all staff had a signed employment agreement, reference checks, police check on file, however, while all employees had a signed job description, copies were not always evident on file.	The kitchen manager, wellness leader, two wellness partners and the registered nurse did not have signed job descriptions on file.	Ensure all staff have a copy of their signed job description which remains on file. 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the	PA Low	Risk assessments are available on the resident management system – eCase, for falls risk, nutritional risk, and pressure injury risk however pain and behaviour assessments had not been completed as required.	Behavioural assessments and behaviour support plans had not been completed for two residents (one rest home and one dementia care) with known behaviours recorded on the behaviour charts. A pain assessment had not been completed for one rest home resident recently returned from hospital with a	i) and ii) Ensure risk assessments are completed to identify supports and needs required. 90 days

basis for service delivery planning.			fracture.	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>i). Care plans reflect the required health monitoring interventions for individual residents however not all monitoring was implemented as required. Caregivers/wellness partners and RNs complete electronic monitoring charts however not all monitoring forms had been implemented for unintentional weight loss.</p> <p>ii). Wound assessments, wound management plans with body map, photos, and evaluations for seven wounds (two lesions, one skin tear and three pressure injuries) were reviewed. Wound assessments for two pressure injuries including sizes were incomplete.</p> <p>iii). Neurological observation charts were reviewed for residents with unwitnessed falls but eight of 10 had not been fully completed.</p> <p>iv). There were no documented outcomes for the effectiveness of as required medications including pain relief for eight of 10 medication charts or progress notes reviewed.</p>	<p>i). There were no implemented interventions for a) one hospital resident requiring weekly weigh and food and fluid chart as per the care plan, b) another hospital resident with undernutrition triggered in the interRAI assessment had unintentional weight loss over three months and c) one dementia care resident had unintentional weight loss and below the recorded ideal weight in the care plan.</p> <p>ii). Wound assessments including for two of three pressure injuries had not been fully completed including objectives and interventions to assist healing. There were no sizes documented for the three pressure injuries.</p> <p>iii). Eight of 10 neurological observations reviewed for residents (all hospital level) with unwitnessed falls had not been completed as per policy.</p> <p>iv). The dates and times of as required medications had been recorded however there was no documented outcomes of the effectiveness of medications including pain relief.</p>	<p>i). Ensure monitoring forms and interventions are implemented to meet resident goals and wellbeing around weight management.</p> <p>ii). Ensure wound assessments are fully completed including size of wounds.</p> <p>iii). Ensure neurological observations are completed as per policy.</p> <p>iv). Ensure the outcome/effectiveness is recorded for as required medications administered.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.