

Presbyterian Support Otago Incorporated - CastleWood

Introduction

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

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

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

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

The specifics of this audit included:

Legal entity: Presbyterian Support Otago Incorporated

Premises audited: CastleWood

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 4 April 2022 End date: 4 April 2022

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: 17

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 sections contained within the Ngā Paerewa Health and Disability Services Standard:

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

General overview of the audit

Castlewood Nursing provides rest home level of care for up to 24 residents. There were 17 residents on the day of audit.

This provisional audit was conducted against the Nga Paerewa Health and Disability Services Standards 2021 and the contracts with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, management, staff, and a general practitioner.

The facility manager is experienced and is supported by the owner. Feedback from residents was very positive about the care and the services provided. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care.

The prospective buyer, Presbyterian Support Otago (PSO), will manage the facility under the PSO umbrella. PSO has a well-established organisational structure, including a governance board, chief executive officer, senior leadership team, clinical

governance advisory group, and the Enliven management team including a clinical nurse advisor, quality advisor, and senior administrator. The service will be supported by the current manager (a registered nurse) at their nearby aged care facility, which is less than 400 metres from Castlewood. PSO's current philosophy, values, quality and risk management systems, policies and procedures will be implemented at Castlewood.

This provisional audit identified that improvements are required in relation to admission agreements and consents, the complaints process, business goals, the quality system, the adverse event process, care plan assessments, care plan reviews, medication management, medication competencies, food and nutrition services, preventative maintenance, emergency management checks, first aid training, infection prevention and control (IPC) responsibility, IPC reviews, IPC procurement, and cleanliness. There was a high-risk shortfall identified around staffing.

Ō tatou motika | Our rights

Castlewood Nursing Home provides an environment that supports resident rights. Staff demonstrated an understanding of residents' rights and obligations. There is a Māori health plan in the policies and procedures. There were no Māori residents at the time of the audit.

Residents receive services in a manner that considers their dignity, privacy, and independence. The staff were observed listening and respecting the voices of the residents and effectively communicating with them about their choices.

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.

Hunga mahi me te hanganga | Workforce and structure

The business plan includes a mission statement and operational objectives. The service has quality and risk management systems established that take a risk-based approach. Staff, resident, and quality meetings are scheduled two monthly. Quality data is collated and analysed with the assistance of an electronic system. Corrective actions are implemented.

There is a staffing and rostering policy. Human resources are managed in accordance with good employment practice. A role specific orientation programme and two-monthly staff education and training are in place.

The service ensures the collection, storage, and use of personal and health information of residents is secure, accessible, and confidential.

Ngā huarahi ki te oranga | Pathways to wellbeing

There is an admission package available prior to or on entry to the service. Care plans viewed demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Senior caregivers responsible for administration of medicines. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

An activities coordinator provides and implement an interesting and varied activity programme. The programme includes outings, and meaningful activities that meet the individual recreational preferences.

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. The service has a current food control plan.

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

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. There is a mix of bedrooms with shared ensuites and others with hand basin facilities. There are communal shower rooms with privacy locks or signage. Rooms are personalised. Documented systems are in place for essential, emergency and security services. Staff have planned and implemented strategies for emergency management including Covid-19.

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

Infection prevention management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation. Documentation evidenced that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. The service has Covid-19 screening in place for residents, visitors, and staff. Covid-19 response plans are in place and the service has access to personal protective clothing (PPE) supplies. There have been no outbreaks. 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. Documented policies and procedures for the cleaning and laundry services are implemented.

Here taratahi | Restraint and seclusion

The restraint coordinator is the facility manager during the absence of a registered nurse. There are no restraints used at Castlewood Nursing Home. Maintaining a restraint-free environment is included as part of the education and training plan. The service considers least restrictive practices, implementing de-escalation techniques and alternative interventions, and would only use an approved restraint as the last resort.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	14	0	5	6	1	0
Criteria	0	114	0	7	9	1	0

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

Attainment against the Ngā Paerewa Health and Disability Services Standard

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

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

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

Subsection with desired outcome	Attainment rating	Audit evidence
<p>Subsection 1.1: Pae ora healthy futures (HDSS.2021:1.1)</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	FA	<p>A Māori Health Plan and Ethnicity Awareness policy is documented for the service. This policy acknowledges the Te Tiriti O Waitangi as a founding document for New Zealand. The aim is to co-design health services using a collaborative and partnership model with Māori and Pacific although the policy focuses on Māori. The service had no residents who identified as Māori.</p> <p>The owner and facility manager confirmed that the service supports increasing Māori capacity by employing more Māori staff members. At the time of the audit the managers were unaware if there are any staff who identify as Māori.</p> <p>Residents and whānau are involved in providing input into the resident's care planning, their activities, and their dietary needs (link 3.2.1). Two care staff interviewed (one healthcare assistant (HCA), one activities coordinator) described how care is based on the resident's individual values and beliefs.</p> <p>Plans are in place to ensure the service promotes a Māori workforce.</p>
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa (HDSS.2021:1.2)</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p>	Not applicable	<p>On admission all residents state their ethnicity. Advised that family members of Pacific residents will be encouraged to be present during the admission process including completion of the initial care plan. There were no residents that identified as Pacifica. For all residents, individual cultural beliefs are documented in their care plan and activities plan (link 3.2.1).</p> <p>The facility manager plans to work towards the development of a Pacific</p>

<p>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.</p> <p>As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.</p>		<p>health plan and plans to seek guidance from a Pacifica organisation and/or individual. The existing plan, which is linked to the Māori health plan, does not adequately address Pacifica.</p> <p>The service is actively recruiting new staff. The facility manager described how they would encourage and support any staff that identified as Pacifica through the employment process. There are currently no staff that identify as Pacifica.</p> <p>Interviews with five staff (two care staff, one maintenance, one housekeeper, one kitchen manager), five residents, and documentation reviewed identified that the service puts people using the services, families, and the Alexandra community at the heart of their service.</p> <p>Work is underway to ensure a Pacific health plan is developed with input from Pacific communities, and Pacific staff are actively recruited.</p>
<p>Subsection 1.3: My rights during service delivery (HDSS.2021:1.3)</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti:Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	<p>FA</p>	<p>The Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. Details relating to the Code are included in the information that is provided to new residents and their relatives. The facility manager discusses aspects of the Code with residents and their relatives on admission.</p> <p>Discussions relating to the Code are held during the two-monthly resident/family meetings. All five residents interviewed reported that their rights are being upheld by the service. Interactions observed between staff and residents during the audit were respectful. Residents were observed freely going outside to take walks. One resident was observed driving his car. Residents interviewed confirmed that they are treated with respect and that their independence is supported and encouraged and that they appreciate this. One resident commented that there was a strong sense of community living at Castlewood.</p> <p>Information about the Nationwide Health and Disability Advocacy Service and the resident advocacy is available to residents. There are links to spiritual supports.</p> <p>Staff receive education in relation to the Health and Disability Commissioners (HDC) Code of Health and Disability Consumers' Rights (the Code) at orientation and through the annual training programme which includes (but not limited to) understanding the role of advocacy services. Advocacy services</p>

		<p>are linked to the complaints process.</p> <p>Plans are underway to ensure that the service recognises Māori mana Motuhake.</p> <p>The prospective owners know and understand the Code and that is must be adhered to, evidenced through interview.</p>
<p>Subsection 1.4: I am treated with respect (HDSS.2021:1.4)</p> <p>The People: I can be who I am when I am treated with dignity and respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake.</p> <p>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.</p>	FA	<p>The healthcare assistant (HCA) interviewed described how they support residents to choose what they want to do. Residents interviewed stated they had choice. Residents are supported to make decisions about whether they would like family/whānau members to be involved in their care or other forms of support.</p> <p>Residents have control over and choice over activities they participate in. A selection of residents interviewed confirmed that they enjoy and appreciate their independence.</p> <p>The services annual training plan demonstrates training that is responsive to the diverse needs of people across the service. It was observed that residents are treated with dignity and respect. Satisfaction surveys completed in July 2020 confirmed that residents and families are treated with respect (link 2.2.2). This was also confirmed during interviews with residents.</p> <p>A sexuality and intimacy policy is in place. Staff interviewed stated they respect each resident's right to have space for intimate relationships.</p> <p>Staff were observed to use person-centred and respectful language with residents. Residents interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy is ensured and independence is encouraged.</p> <p>Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with relative's involvement and is integrated into the residents' care plans (link 3.2.1). Spiritual needs are identified. A spirituality policy is in place.</p> <p>Work is underway to actively promote te reo Māori and tikanga Māori, ensure staff attend specific cultural training that covers Te Tiriti o Waitangi and tikanga Māori, and ensure that staff participate in te ao Māori.</p>
Subsection 1.5: I am protected from abuse	FA	An abuse and neglect policy is being implemented. Castlewood Nursing

<p>(HDSS.2021:1.5)</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>		<p>Home policies prevent any form of discrimination, coercion, harassment, or any other exploitation. Inclusiveness of all ethnicities, and cultural days are completed to celebrate diversity. A staff code of conduct is discussed during the new employee's induction to the service with evidence of staff signing the code of conduct policy. This code of conduct policy addresses harassment, racism, and bullying.</p> <p>Staff complete education on orientation and annually as per the training plan on how to identify abuse and neglect. Staff are educated on how to value the older person showing them respect and dignity. All residents and families interviewed confirmed that the staff are very caring, supportive, and respectful. The relative interviewed confirmed that the care provided to their family member is excellent.</p> <p>Police checks are completed as part of the employment process. The service implements a process to manage residents' comfort funds, such as sundry expenses. A staff code of conduct is discussed during the new employee's induction to the service with evidence of staff signing the code of conduct policy. Professional boundaries are defined in job descriptions. Interviews with registered nurses and HCAs confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation.</p>
<p>Subsection 1.6: Effective communication occurs (HDSS.2021:1.6)</p> <p>The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing.</p> <p>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.</p> <p>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.</p>	<p>FA</p>	<p>Information is provided to residents/relatives on admission. Two-monthly resident meetings identify feedback from residents and consequent follow-up by the service.</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. Accident/incident forms failed to consistently indicate if next of kin have been informed (or not) of an accident/incident (link 2.2.5). No relatives were available during the audit for interview.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. At the time of the audit, there were no residents who did not speak English.</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. The residents and family are informed prior to entry of the scope of services and</p>

		<p>any items that are not covered by the agreement.</p> <p>The service communicates with other agencies that are involved with the resident such as the DHB specialist services.</p>
<p>Subsection 1.7: I am informed and able to make choices (HDSS.2021:1.7)</p> <p>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health,</p> <p>keep well, and live well.</p> <p>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.</p>	PA Low	<p>There are policies around informed consent. The six resident files reviewed (including one ACC respite), included general consent forms, however not all had been signed by the resident or their representative. There were signed specific agreements in place for covid and flu vaccines. Residents interviewed could describe what informed consent was and knew they had the right to choose.</p> <p>There is an advance directive policy which is implemented. In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. All files reviewed had admission agreements however not all had been signed. Copies of enduring power of attorneys (EPOAs) were on resident files where available.</p> <p>The service is working towards a process to apply the appropriate best practice tikanga guidelines in relation to consent.</p>
<p>Subsection 1.8: I have the right to complain (HDSS.2021:1.8)</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p> <p>As service providers: We have a fair, transparent,</p>	PA Low	<p>The complaints procedure is provided to residents and relatives on entry to the service. The facility manager maintains records of complaints, actions taken, and resolution; but this information (2021 and 2022 (year to date)) is not held in one centralised register.</p> <p>Seven complaints were logged in a complaint register in 2020. Only one complaint was lodged for 2021 and one complaint was lodged in 2022 (year to date). In relation to the complaint received in 2021, time frames for responding to the complaint met timeframes determined by HDC. The complaint lodged in March 2022 remains under investigation. The facility manager stated that he addresses concerns as they arise and has received very few complaints. Staff are informed of any complaints received in the</p>

<p>and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>		<p>quality and staff meetings (meeting minutes sighted).</p> <p>Discussions with residents confirmed they were provided with information on complaints and complaints forms are available at the entrance to the facility. Residents have a variety of avenues they can choose from to make a complaint or express a concern. Resident meetings are held two-monthly, chaired by the activity coordinator.</p> <p>Residents/relatives making a complaint can involve an independent support person in the process if they choose. This was documented as an option in a (final) letter that was sent to one complainant.</p>
<p>Subsection 2.1: Governance (HDSS.2021:2.1)</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>PA Low</p>	<p>Castlewood Nursing Home, located in Alexandra, is certified for 24 rest home level beds. At the time of the audit there were 17 residents in the facility. Two residents were on respite (one ACC) and one resident was on an individualised funding contract. The remaining residents were on the age-related residential care agreement (ARRC).</p> <p>The 2020-2022 business plan outlines the business direction, objectives, and values. The service's values are displayed in the facility lounge.</p> <p>There is no board of directors or formal governance structure. Castlewood has been owned for over 30 years by a sole owner/licensee who has overall responsibility for the facility.</p> <p>A facility manager is responsible for the day-to-day activities of the facility. The facility manager has been in the role for two years and has previous experience in hospitality management; adult intellectual disabilities services and is an elected member of a local council. Responsibilities and accountabilities of the facility manager position are defined in a job description and individual employment agreement. Interview with the facility manager confirmed his understanding of the sector, regulatory and reporting requirements. He is responsible for the day-to-day running and operational management of the facility and is employed on a part time basis (28 hours per week). At the time of the audit, he was not receiving any support from an RN (link 2.3.1).</p> <p>The business plan includes a mission and operational objectives. Goals are defined and regularly reviewed on an information basis by the village manager, however, there was a lack of documented evidence to indicate that these goals are regularly reviewed at defined intervals.</p>

		<p>Work is underway to ensure that the service collaborates with mana whenua in business planning and service development to improve outcomes and achieve equity for Māori; to identify and address barriers for Māori for equitable service delivery, and to ensure that the owner and facility manger attend cultural training.</p> <p>The prospective buyer, Presbyterian Support Otago (PSO), will manage the facility under the PSO umbrella. PSO has a well-established organisational structure, including a governance board, chief executive officer, senior leadership team, clinical governance advisory group, and the Enliven management team including a clinical nurse advisor, quality advisor, and senior administrator. The service will be supported by the current manager (a registered nurse) at their nearby aged care facility, which is less than 400 metres from Castlewood. PSO's current philosophy, values, quality and risk management systems, policies and procedures will be implemented at Castlewood.</p> <p>PSO has entered into a conditional sale and purchase agreement for the purchase of the Castlewood Nursing Home. The agreement, dated 1 March 2022, allows for a 60 working day due diligence period, which expires on 30 May 2022. Assuming PSO confirms the agreement, and the contract goes unconditional, the settlement/possession date is 20 days after the contract becomes unconditional. Therefore, if the contract is confirmed on 30 May 2022, then the possession date will be 30 June 2022.</p> <p>A detailed transition plan is documented and is being implemented.</p> <p>Discussions have been undertaken with the planning and funding manager, Southern District Health Board, and they have their full support to progress with the purchase.</p>
<p>Subsection 2.2: Quality and risk (HDSS.2021:2.2)</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous</p>	<p>PA Moderate</p>	<p>Castlewood Nursing Home has an established quality and risk management programme, designed by Health Compliance Solutions Ltd (HCSL). A strengths, weakness, opportunities, and threats (SWOT) analysis is included as part of the business plan. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Internal audits have fallen behind schedule since 2020. Clinical indicator data is collected electronically with evidence of data shared in the quality and staff meetings.</p> <p>Two-monthly quality meetings and two-monthly staff meetings provide an</p>

<p>quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>		<p>avenue for discussions in relation to (but not limited to) quality data, health and safety, infection control/pandemic strategies, complaints received (if any), staffing, and education. Corrective actions are documented to address service improvements with evidence of progress and sign off when achieved as per the HCSL system. The resident and family satisfaction surveys have not taken place for over one year. Surveys completed in 2020 reflected evidence of two corrective actions implemented around ensuring residents are informed of the complaints process and addressing concerns from residents around ventilation and drafts.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. A document control system is in place. Policies are regularly reviewed by HCSL and have been updated to reflect the 2021 Ngā paerewa standards.</p> <p>A health and safety system is in place with the facility manager the health and safety officer. Hazard identification forms and an up-to-date hazard register were sighted. Health and safety policies are implemented by the facility manager and maintenance staff. There are manual handling training sessions for staff. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form.</p> <p>Individual falls prevention strategies are in place for residents identified at risk of falls. Strategies implemented to reduce the frequency of falls include intentional rounding and the regular toileting of residents who require assistance.</p> <p>Each incident/accident is recorded electronically using the HCSL system. Ten accident/incident forms reviewed (witnessed and unwitnessed falls, skin tears, bruising) indicated that the forms are completed in full although signoff on all accidents and incidents are undertaken by the (non-clinical) facility manager. Incident and accident data is collated monthly and analysed. Results are discussed in the quality and staff meetings. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse until March 2022 (link 2.3.1). Neurological observations were not consistently recorded for unwitnessed falls (link 3.2.4).</p> <p>Discussions with the facility manager evidenced his awareness of their requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification completed to notify HealthCERT around issues relating to RN cover since the previous audit. A section 31</p>
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		<p>report was completed for a police investigation in response to the previous (surveillance) audit. There have been no outbreaks.</p> <p>The prospective provider has an established and implemented quality plan in place that they plan to implement at Castlewood.</p>
<p>Subsection 2.3: Service management (HDSS.2021:2.3)</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	<p>PA High</p>	<p>There is a staffing policy that describes rostering. The roster provides insufficient and appropriate coverage for the effective delivery of care and support and fails to meet contractual requirements. A registered nurse has not been available since 7 March 2022. A section 31 was sent to HealthCERT to notify them of this situation.</p> <p>Interviews with staff confirmed that although they are very busy, overall staffing of healthcare assistants (HCAs) is adequate to meet the needs of the residents. Staff reported high levels of staff turnover. Agency has been used in the past to assist with RN cover.</p> <p>The owner lives on site and is available approximately 20 hours a week. He oversees financial operations. The facility manager is employed for 28 hours per week and is onsite from Monday – Thursday from 1000 – 1630 and works from home for four hours per week.</p> <p>Castlewood, with 17 rest home level residents, is staffed with three HCAs on the AM shift (one long (eight hour) shift and two short shifts (one HCA from 0700 – 1200 with an additional hour on weekends; and one HCA from 0930 – 1030). Two HCAs are rostered on the PM shift (one long shift and one short shift (1630 – 1830 with an additional hour on weekends). One HCA is rostered on the night shift.</p> <p>A designated (level four) HCA is on call. GP cover is located at the adjacent medical practice during normal working hours. Staff are instructed to call an ambulance in the event of a medical emergency after hours.</p> <p>There are separate cleaning staff. HCAs assist with laundry duties.</p> <p>Out of a total of 12 HCAs, one has completed their level two Careerforce qualification. Four caregivers hold a level four qualification based on their years of experience working in aged care.</p> <p>A competent care provision policy is being implemented. Competencies completed over the past 12 months include a communication quiz, documentation quiz, manual handling, food safety, wound care, weight</p>

		<p>management, fire evacuation and wound care. Medication competencies have fallen behind schedule (3.4.3). Training sessions covered over the past 24 months cover code of rights, aging process, infection control/hand hygiene, continence, wound care and falls prevention.</p> <p>The service encourages all their staff to attend two-monthly meetings (e.g. staff meetings, quality meetings). Resident/family meetings are also held two-monthly, chaired by the activities coordinator.</p> <p>Training, support, performance, and competence are provided to staff to ensure health and safety in the workplace including manual handling, chemical safety, emergency management including (six-monthly) fire drills and personal protective equipment (PPE) training.</p> <p>The prospective owners will ensure that all new staff are provided with a comprehensive orientation in line with PSO's orientation procedures. They plan to provide all staff with mandatory training (e.g. fire safety and evacuation procedures, medication management, skin care and pressure area prevention, first aid, health and safety, infection prevention and control (including safe use of PPE), and safety chemical training. Specific competencies will be completed for all care staff including medication and restraint competencies, manual handling, hand hygiene and wound care. Changes to the roster will be covered by staff at their Ranui age care facility where possible.</p>
<p>Subsection 2.4: Health care and support workers (HDSS.2021:2.4)</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and</p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Staff files are held in the facility manager's office in a locked filing cabinet. Five staff files reviewed (four HCAs, one housekeeper) evidenced implementation of the recruitment process, employment contracts, police checking and completed orientation.</p> <p>There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position.</p> <p>A register of practising certificates is maintained for all health professionals (e.g. RNs, GPs, pharmacy, podiatry). There is an appraisal policy. All staff who had been employed for over one year had an annual appraisal completed with the facility manager completing 90-day performance appraisals for new staff.</p>

<p>qualified to provide clinically and culturally safe, respectful, quality care and services.</p>		<p>The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programmes support staff to provide a culturally safe environment for the residents. Volunteers have not been utilised due to Covid.</p> <p>Information held about staff is kept secure, and confidential. At the time of the audit, ethnicity data was not being collected.</p> <p>Staff reported that there has been very high turnover of staff which has affected their well-being.</p>
<p>Subsection 2.5: Information (HDSS.2021:2.5)</p> <p>The people: Service providers manage my information sensitively and in accordance with my wishes.</p> <p>Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity.</p> <p>As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.</p>	<p>FA</p>	<p>The staff area for documentation is located in an alcove in the dining room referred to as the 'nurses station'. Whilst not ideal, resident information is held in a confidential manner. Resident files are held on the electronic HCSL system. Electronic information are backed-up and password protected. Hard copy information is held in a locked cupboard.</p> <p>The resident files are appropriate to the service type and demonstrated service integration. Records are uniquely identifiable, legible, and timely. Signatures are documented and include the designation of the service provider.</p> <p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is scheduled to be developed at this time (link 3.2.1).</p> <p>The prospective buyers plan to transfer all resident information to PSO's V-Care electronic resident management system which is implemented at their other aged care facilities.</p>
<p>Subsection 3.1: Entry and declining entry (HDSS.2021:3.1)</p> <p>The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs are provided for families and residents prior to admission or on entry to the service. The revised admission agreement aligns with all contractual requirements. Exclusions from the service are included in the revised admission agreement, however, not all admission agreements were signed (link 1.7.5).</p> <p>The residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service.</p>

<p>by ensuring fair access to quality care.</p> <p>As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.</p>		<p>The service has policies and procedures to support the admission or decline entry process. Admission criteria is based on the assessed need of the resident and the contracts under which the service operates. The facility manager is available to answer any questions regarding the admission process. The service communicates with potential residents and whānau during the admission process. Declining entry would only be if there were no beds available or the potential resident did not meet the admission criteria. The service collects ethnicity information at the time of admission from individual residents. This is recorded on the admission form and on the lifestyle profile, however, the facility does not currently identify entry and decline rates for Māori and is working on a process to collate this information. The manager reports they are working towards establishing links to local Māori health practitioners and Māori health organisations to improve health outcomes for future Māori residents</p>
<p>Subsection 3.2: My pathway to wellbeing (HDSS.2021:3.2)</p> <p>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>PA Moderate</p>	<p>The care plan policy and procedure guides staff around admission processes, required documentation including interRAI, risk assessments, care planning, the inclusion of cultural interventions, and timeframes for completion and review of care plans.</p> <p>Six resident rest home files were reviewed (five ARRC contract and one ACC respite contract). A registered nurse (RN) is responsible for conducting all assessments and for the development of care plans, however the previous RN finished employment in early March and has not yet been replaced (link 2.3.1). There is evidence of resident and whānau involvement in the interRAI assessments and long-term care plans reviewed and this is documented in progress notes and family contact forms.</p> <p>All residents including the respite resident have admission assessment information collected and an initial care plan completed within required timeframes. The facility manager advised that since the resignation of the permanent registered nurse late last year and the agency contract nurse three to four weeks ago, clinical input into interRAI assessments and care planning has not been provided. Not all long-term care plans have been updated with identified changes in care needs, and not all interRAI assessments and care plans reviews have been completed within the required timeframes the last year. Evaluations are scheduled to be completed six- monthly, however these</p>

		<p>had not occurred as required for the five permanent resident files reviewed.</p> <p>The long-term care plan includes sections on mobility, continence, activities of daily living, nutrition, pain management, sleep, sensory and communication, medication, skin care, cognitive function, and behaviours, cultural, spiritual, sexuality, and diversional therapy. Risk assessments are conducted on admission relating to falls, pressure injury, continence, nutrition, skin, and pain. A specific cultural assessment has not yet been implemented.</p> <p>All residents had been assessed by the general practitioner (GP) within five working days of admission. The GP reviews the residents at least three monthly or earlier if required. General practitioners from the adjacent medical centre provide medical oversight. Residents generally attend the clinic accompanied by care staff for three monthly reviews or when indicated for changes in health needs. The GP's will visit residents on site if required. Weekend on call cover is provided by local medical centres on a rotational basis. After hours during the week, the local hospital provides on call services. One of the GPs (interviewed) commented positively on the care, communication, and the quality of the care staff. Specialist referrals are initiated as needed. Allied health interventions were documented and integrated into care plans. The service has access to a physiotherapist when required. A podiatrist visits regularly and a dietitian, speech language therapist and wound care specialist nurse is available as required through the local DHB.</p> <p>Care staff interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery, this was sighted on the day of audit. Progress notes are documented by care staff twice daily and as necessary by GP's and allied health. There was evidence the RN has added to the progress notes when there was an incident or changes in health status, however this has not occurred over the previous four weeks due to no registered nurse (link 2.3.1).</p> <p>Residents interviewed reported their needs and expectations were being met. When a resident's condition alters, the senior caregiver or the facility manager initiates a review with a GP. The electronic progress notes reviewed provided evidence that family have been notified of changes to health including infections, accident/incidents, GP visit, medication changes and any changes to health status. This was confirmed through the interview of one family member. Eight wound assessments and wound management plans including wound measurements were reviewed for three residents with wounds (skin</p>
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		<p>tears, skin conditions, blisters and one grade one pressure injury). The wound register has not been fully maintained since October 21.</p> <p>There is access to wound expertise from the registered nurses at the adjacent medical centre. 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. Care plans reflect the required health monitoring interventions for individual residents. Care staff complete monitoring charts including bowel chart, blood pressure, weight, food and fluid chart, blood sugar levels and toileting regime, however monitoring charts have not always been completed as scheduled. Neurological observations have not routinely and comprehensively been completed for unwitnessed falls.</p> <p>Written evaluations reviewed did not always identify if the resident goals had been met or unmet... Short term care plans had previously been well utilised for issues such as infections, weight loss, and wounds, however in the absence of a registered nurse, open short term care plans (STCP's) have not been maintained or evaluated.</p>
<p>Subsection 3.3: Individualised activities (HDSS.2021:3.3)</p> <p>The people: I participate in what matters to me in a way that I like.</p> <p>Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.</p> <p>As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.</p>	<p>FA</p>	<p>There is one activities coordinator who works Monday to Friday for twenty hours a week. The overall programme has integrated activities that is appropriate for the cohort of residents. The activities are displayed and include exercises newspaper reading, baking, shopping trips, silver cleaning, golf putting, word games, board games, craft, van outings, quizzes, and seasonal celebrations. The programme allows for flexibility and resident choice of activity. Community visitors include entertainers, and church services when COVID restrictions allow. Residents are encouraged to maintain links to the community.</p> <p>There is a large lounge and separate dining room where group activities can occur. One-on-one activities such as individual walks, chats and hand massage/pampering occur for residents who are unable to participate in activities or choose not to be involved in group activities. The residents enjoy attending the activities and enjoy contributing to the programme.</p> <p>A resident lifestyle profile and activity assessment informs the activities plan. Individual activities plans were seen in resident files reviewed. Monthly progress notes are completed by the activities coordinator, however, activities plans have not always been evaluated six-monthly in conjunction with the</p>

		<p>resident long term care plan (link 3.2.5). The service receives feedback and suggestions for the programme through resident meetings and resident surveys (link 2.2.2). The residents interviewed were happy with the variety of activities provided.</p> <p>The prospective purchaser has no immediate plans to change the activities programme.</p>
<p>Subsection 3.4: My medication (HDSS.2021:3.4)</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management. Medications are stored safely in a locked treatment room. Medication competencies are expected to be completed by HCAs however, with no RN on site, these have not been maintained. Regular medications are administered from prepacked robotic sachets and 'as required' medications are delivered in blister packs. The senior caregiver checks the packs against the electronic medication chart and a record of medication reconciliation is maintained. Any discrepancies are fed back to the supplying pharmacy (also available on call). Expired medications are documented on a medication return form and returned to pharmacy weekly. Healthcare assistants advised there were no self-medicating residents on the day of audit. Controlled drugs are administered by HCAs. Not all residents who are on regular or as required medications have clinical assessments conducted by a registered nurse.</p> <p>The medication fridge temperatures and room air temperature are checked at least weekly and recorded. Temperatures had been maintained within the acceptable temperature range. Eye drops were dated on opening but were noted to be past expiry date for some eye drops. Ten electronic medication charts were reviewed and met prescribing requirements. Medication charts had photo identification and allergy status notified. The GP had reviewed the medication charts three-monthly and discussion and consultation with residents takes place during these reviews and if additions or changes are made. Not all 'as required' medications had prescribed indications for use. The effectiveness of 'as required' medication had been documented in the medication system.</p> <p>Standing orders are not in use. All medications are charted either regular doses or as required. Over the counter medications are prescribed on the electronic medication system.</p> <p>The prospective buyer intends to ensure all staff receive training in medication</p>

		management and to complete annual medication competencies for staff involved in medication administration.
<p>Subsection 3.5: Nutrition to support wellbeing (HDSS.2021:3.5)</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	PA Low	<p>The food services are overseen by a kitchen manager. All meals and baking are prepared and cooked on site by experienced cooks. All food services staff have completed food safety training. The four-week winter menu is due for review by a registered dietitian. The 4-week summer menu has not been reviewed in the last two years. The kitchen receives resident dietary forms and is notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated including food allergies. The menu provides pureed/soft meals. The service caters for residents who require texture modified diets and other foods. The kitchen is adjacent to the main dining room and meals are plated in the kitchen and served to residents in the dining room.</p> <p>Residents may choose to have meals in their rooms. The food control plan is due to expire 30 April 2022. Temperature checks are recorded for freezers, fridge, inward goods, end-cooked foods, reheating (as required), and serving temperatures. Resident preferences are considered with menu reviews. Residents interviewed expressed their satisfaction with the meal service. All perishable foods and dry goods in original packaging were date labelled. There is partial decanting of dry goods. Not all decanted foods were dated. Cleaning schedules are documented but not consistently maintained (link 5.5.3). Staff were observed to be wearing appropriate personal protective clothing. Chemicals were stored safely. Chemical use and dishwasher efficiency is monitored. Residents provide verbal feedback on the meals through the two to three monthly resident meetings. Information about meals is documented on meeting minutes and passed on to the facility manager who signs as acknowledgment of receipt.</p> <p>Residents are weighed monthly unless this has been requested more frequently due to weight loss with exceptions (link 3.2.4). This is recorded in the medication management system and is graphed. The long-term care plan section for nutritional needs identifies food and fluid texture requirements, allergies, and any swallowing difficulties. These sections were completed in the six resident files reviewed.</p> <p>The prospective buyer plans to ensure the menu is reviewed by a registered dietitian, to provide modified diets, nutritious snacks 24/7 and accommodate resident choices. Resident weights will be monitored monthly or more</p>

		frequently as required.
<p>Subsection 3.6: Transition, transfer, and discharge (HDSS.2021:3.6)</p> <p>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.</p>	FA	<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 exits or discharges to and from the service.</p>
<p>Subsection 4.1: The facility (HDSS.2021:4.1)</p> <p>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>	PA Moderate	<p>The building holds a current warrant of fitness which expires 1 July 2022. The maintenance person works up to 30 hours a week (Monday to Friday). There is a maintenance request book for repair and maintenance requests located in the nurse's station. This is checked daily and signed off when repairs have been completed. There is an annual preventative maintenance plan documented but not implemented. Hot water temperatures are checked by the facility manager and are consistently documented at 45 degrees. Essential contractors/tradespeople are available 24 hours as required. Testing and tagging of electrical equipment was last completed in November 2020. Electrical equipment bought into Castlewood since then have not been completed. Medical equipment, and scales were last calibrated in July 2020.</p> <p>The maintenance role includes maintenance of the gardens and grounds. The corridors are suitable for safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external courtyards and gardens have seating and shade. There is safe access to all communal areas. Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home and</p>

		<p>hospital level of care residents.</p> <p>Eleven resident rooms have shared ensuites with privacy locks and all other rooms have hand basin ensuites. There are communal bathrooms/showers located close to the resident rooms within the facility with privacy signage. Fixtures, fittings, and flooring are appropriate. Toilet/shower facilities are easy to clean. There is sufficient space in toilet and shower areas to accommodate shower chairs and commodes. There are sufficient communal toilets situated in the vicinity of the lounge and dining room – A toilet near the main lounge is available for visitors.</p> <p>There is one double room which is currently single occupancy.</p> <p>There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Healthcare assistants interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p> <p>The dining room is adjacent to the kitchen and open plan with doors that open out to a garden with outdoor seating and shade. There is a main lounge and a smaller annex area off the main lounge. There is safe access to the courtyards and gardens. All communal areas are easily accessible for residents with mobility aids with ramp access. All bedrooms and communal areas have sufficient natural light and ventilation.</p> <p>There is electric wall heating in resident rooms, corridors and bathrooms and heat pumps in communal areas.</p> <p>The prospective purchasers are not planning environmental changes to the facility.</p>
<p>Subsection 4.2: Security of people and workforce (HDSS.2021:4.2)</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an</p>	<p>PA Moderate</p>	<p>Emergency management policies, including the pandemic plan, outlines the specific emergency response and evacuation requirements as well as the duties/responsibilities of staff in the event of an emergency. Emergency management procedures guide staff to complete a safe and timely evacuation of the facility in the case of an emergency.</p> <p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. A fire evacuation drill is repeated six-monthly in accordance with the facility's building warrant of fitness. The last drill took place on 13 December 2021. Missing is evidence of annual checks of the fire</p>

<p>emergency or unexpected event.</p>		<p>extinguishers and fire hoses.</p> <p>There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Civil defence supplies are stored in an identified cupboard. In the event of a power outage there is back-up power available and gas cooking. There are adequate supplies in the event of a civil defence emergency including 3000 litres of water stored to provide residents and staff with three litres per day for a minimum of three days. Emergency management is included in staff orientation and external contractor orientation. It is also ongoing as part of the education plan. A minimum of one person trained in first aid is not available at all times.</p> <p>There are call bells in the residents' rooms and ensuites, communal toilets and lounge/dining room areas. Indicator lights are displayed above resident doors to alert them of who requires assistance. Residents were observed to have their call bells in close proximity when in their room. Residents interviewed confirmed that call bells are answered in a timely manner.</p> <p>The building is secure after hours, staff complete security checks at night.</p>
<p>Subsection 5.1: Governance (HDSS.2021:5.1)</p> <p>The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately.</p> <p>Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance.</p> <p>As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.</p>	<p>FA</p>	<p>The owner is responsible for governance attends the management meeting and is informed of infection data. The management team discusses current infection concerns. The infection prevention plan is developed by an external consultant and collated data is reviewed against this.</p> <p>In the absence of a registered nurse, the non-clinical facility manager oversees infection control and prevention across the service. The job description outlines the responsibility of the role. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. Infection control is linked into the quality risk and incident reporting system. Infection control audits are scheduled twice a year (link 2.2.2). The facility manager is part of the management team where infection matters are raised.</p> <p>The service has access to an infection prevention clinical nurse specialist from the local DHB. The DHB nurse specialist has had input into the facilities infection preparedness review which included recommending refurbishment of the sluice room.</p> <p>Visitors are asked not to visit if unwell. Covid-19 screening continues for visitors and contractors.</p>

		<p>There are hand sanitisers strategically placed around the facility. Residents and staff are offered influenza vaccinations and all residents are fully vaccinated against Covid-19. Visitor controls are in place and all staff perform rapid antigen test (RAT) daily. There were no residents with Covid-19 infections on the days of audit.</p> <p>The prospective buyer plans to appoint a designated infection prevention coordinator. The infection control coordinator will be supported by the Enliven Clinical Nurse Advisor who is the organisation Infection Control Coordinator.</p> <p>Presbyterian Support Otago has an established infection prevention and control programme, which will be implemented at Castlewood. The transition plan includes plans to appoint a designated infection control home coordinator with oversight by the Enliven clinical nurse advisor. Education will be provided at orientation to the service and included in the education plan.</p>
<p>Subsection 5.2: The infection prevention programme and implementation (HDSS.2021:5.2)</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	<p>PA Moderate</p>	<p>The facility manager (non-clinical) has interim responsibility for infection control prevention and coordination while the service is without a registered nurse. The facility manager is supported by the DHB nurse specialist, senior HCA's and general practitioners who can provide input when requested.</p> <p>The facility manager is liaising with the DHB and the GP regarding procurement processes or equipment, devices, and consumables used in the delivery of health care. The service is using the Ministry of Health portal to order consumable personal protective clothing. During Covid-19 lockdown there were regular zoom meetings with the DHB Age Residential Care CNS which provided a forum for discussion and support for facilities. The service has a Covid-19 response plan approved by the DHB nurse specialist which includes preparation and planning for the management of lockdown, screening, transfers into the facility and positive tests should this occur. There are outbreak kits readily available and sufficient additional supplies are stored in a personal protective equipment cupboard.</p> <p>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 are available to staff electronically. Annual review of the infection prevention programme has not been undertaken.</p> <p>There are policies and procedures in place around reusable and single use equipment. All shared equipment is appropriately disinfected between use.</p>

		The external contractor responsible for policy development is working towards incorporating the relevant information around infection control for Maori residents and encouraging culturally safe practices acknowledging the spirit of Te Tiriti. There are no plans to change the current environment, however, the service will consult with the infection control coordinator if this occurs.
<p>Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation (HDSS.2021:5.3)</p> <p>The people: I trust that my service provider is committed to responsible antimicrobial use.</p> <p>Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant.</p> <p>As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.</p>	FA	The service has anti-microbial use policy and procedures which have been developed by an external consultant and are appropriate for the size and scope of the service. Antibiotic and antimicrobial use is recorded in medication records and medical notes. Monthly infection rates are reviewed monthly and reported to the management meetings.
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI) (HDSS.2021:5.4)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p>	FA	Infection surveillance is an integral part of the infection control programme and is described in the Castlewood policies and procedures. Monthly infection data is collected for 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 where known) is entered onto a monthly infection summary. Infection surveillance is collated monthly by the facility manager. This information is discussed at two to three monthly management meetings and concerns are discussed at staff meetings. The service receives email notifications and alerts from the DHB for any community concerns. There have been no outbreaks in the past 12 months.
<p>Subsection 5.5: Environment (HDSS.2021:5.5)</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the</p>	PA Moderate	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for

<p>environment.</p> <p>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible.</p> <p>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.</p>		<p>containers. Gloves and aprons are available for staff and they were observed to be wearing these as they carried out their duties on the days of audit. There is a sluice tub located within the laundry with personal protective equipment available including a face visor available. Staff have completed chemical safety training. A chemical provider monitors the effectiveness of chemicals.</p> <p>All laundry is processed on site by HCAs. The laundry has a defined clean/dirty flow. The housekeeping team have received appropriate training. The cleaners' trolleys were attended at all times and are stored in a locked cupboard when not in use. All chemicals on the cleaner's trolley were labelled. There was appropriate personal protective clothing readily available. Cleaning and laundry services are monitored through the internal auditing system and the chemical provider who also monitors the effectiveness of chemicals and the laundry/cleaning processes (link 2.2.2). Staff have completed chemical safety training.</p> <p>The transition plan includes changes to the laundry services to be completed by June 2022. There are no proposed changes to the cleaning staff.</p>
<p>Subsection 6.1: A process of restraint (HDSS.2021:6.1)</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>	FA	<p>Restraint policy confirms that restraint consideration and application must be done in partnership with families, and the choice of device must be the least restrictive possible. At all times when restraint is considered, the facility will work in partnership with Māori, to promote and ensure services are mana enhancing. At the time of the audit, the facility was restraint-free.</p> <p>The facility, led by the facility manager, is committed to providing services to residents without use of restraint. The use of restraint (if any) would be reported in the two-monthly quality meetings.</p> <p>Maintaining a restraint-free environment is included as part of the mandatory training plan and orientation programme.</p>
<p>Subsection 6.2: Safe restraint (HDSS.2021:6.2)</p> <p>The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first.</p>	Not applicable	Not applicable

<p>Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort.</p> <p>As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.</p>		
<p>Subsection 6.3: Quality review of restraint (HDSS.2021:6.3)</p> <p>The people: I feel safe to share my experiences of restraint so I can influence least restrictive practice.</p> <p>Te Tiriti: Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions.</p> <p>As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.</p>	<p>Not applicable</p>	<p>Not applicable</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.7.5</p> <p>I shall give informed consent in accordance with the Code of Health and Disability Services Consumers' Rights and operating policies.</p>	PA Low	All six resident files reviewed had admission agreements and general consents included as part of the admission process, however, not all agreements or consents were signed appropriately. There were signed specific agreements in place for covid and flu vaccines.	<p>i). Three of six resident files reviewed did not have a signed admission agreement.</p> <p>ii). Three of six resident files did not evidence general consent forms were signed appropriately.</p>	<p>i). & ii). Ensure all admission agreements and general consents are signed appropriately.</p> <p>90 days</p>
<p>Criterion 1.8.2</p> <p>I shall be informed about and have easy access to a fair and responsive complaints process that is sensitive to, and respects, my values and beliefs.</p>	PA Low	The complaints process is not centralised within a complaints register to reflect evidence of complaints being acknowledged, investigated, and resolved as per time frames determined by the Health and Disability Commissioner. The facility manager stated that after his hours reduced from full time (2020) to part-time, he was unable to maintain this register due	A complaints register, which reflects evidence of each complaint received being acknowledge, investigated, and followed through to resolution has not been maintained since 2020.	Ensure all complaints, actions and evidence of closure are maintained in a central location as per the complaints policy and procedure.

		to time constraints.		90 days
<p>Criterion 2.1.2</p> <p>Governance bodies shall ensure service providers' structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.</p>	PA Low	Business goals are defined in the business plan but there was no evidence to indicate that goals are regularly reviewed.	There is a lack of documented evidence to indicate that business goals are regularly monitored, reviewed, and evaluated at defined intervals.	<p>Ensure that the business goals are monitored, reviewed, and evaluated at defined intervals.</p> <p>90 days</p>
<p>Criterion 2.2.2</p> <p>Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.</p>	PA Moderate	A number of areas relating to quality and risk have fallen behind schedule in 2021 and 2022 (year-to-date). Effective 2021, the internal audit programme has not been completed as per the schedule, and resident/family satisfaction surveys were last completed in 2020. The facility manager reported that this has happened because his hours were reduced in 2021 from full time to 28 hours per week.	<p>i) Thirty-five internal audits were completed in 2020 as per the internal audit schedule. Only five internal audits were completed in 2021 and only three of sixteen audits (year-to-date) have been completed in 2022.</p> <p>ii) Resident/family satisfaction surveys were last conducted in July 2020.</p>	<p>i) Ensure internal audits are completed as per the internal audit schedule.</p> <p>ii) Ensure resident/family satisfaction surveys are completed a minimum of annually.</p> <p>60 days</p>
<p>Criterion 2.2.5</p> <p>Service providers shall follow the National Adverse Event Reporting Policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learnings.</p>	PA Moderate	<p>An adverse event reporting policy is being following by the service. Adverse events are documented electronically on the HCSL system. Data is collated and trends are identified. Accident/incident reports include space to document that family are kept informed. This has been an RN responsibility in the past and is a gap with the current situation of no RN available.</p> <p>An RN is not available to sign off on adverse events and therefore the facility</p>	<p>i). Adverse events have not been signed off by an RN since early March 2022.</p> <p>ii). Ten incident accident reports reviewed indicated that only two families were kept informed following an adverse event.</p>	<p>i). Ensure adverse events are reviewed and signed off by an RN.</p> <p>ii). Ensure there is evidence of open communication with residents and their family (where applicable) following any adverse event.</p>

		manager has been signing them off with preventable actions listed. The facility manager has addressed this shortfall in the past and stated that he would need to remind staff again.		60 days
<p>Criterion 2.3.1</p> <p>Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.</p>	PA High	<p>As per the ARC contract with the DHB, a rest home level aged care facility is required to employ, contract, or otherwise engage at least one RN to be responsible for working with staff to assess each resident, develop care plans, advise on care and medication administration, provide, and supervise care, act as a resource person, monitor staff competence, advise on staff training needs, and assist with the development and implementation of policies and procedures.</p> <p>Since the beginning of March and earlier, assessments and care plans have not been updated (link 3.2.1 and 3.2.5 and recommendations 3.2.3 and 3.2.4). Wound care documentation has not been maintained (link recommendation 3.2.4). Weekly medication checks have not been performed by qualified staff (link 3.4.2) and a sample of medication competencies (three) are overdue as suitably qualified staff are not available (link 3.4.3). There is lack of infection control oversight (link 5.2.1).</p> <p>Work is underway to employ another RN as soon as possible with the facility manager stating he had a couple of leads. HealthCERT and the DHB have been informed of this situation.</p> <p>The prospective buyer operates an aged</p>	The service does not have a current employed or contracted registered nurse as per the ARC contract D17.3e. There has not been a registered nurse employed since 7 March 2022.	<p>Ensure a registered nurse is engaged to meet the requirements of the ARC contract D17.3 e i-viii.</p> <p>7 days</p>

		care facility that is located approximately 400 meters from Castlewood Nursing Home. They plan to share an RN between the two sites, with onsite RN input budgeted at 25 hours per week. HCA staffing will provide two long shift HCAs on the AM shift, one long and one short shift HCA (1530-2130) on the PM shift and one HCA on the night shift. A designated HCA will be on call. Twenty hours of activities and five hours of exercise therapy are also budgeted.		
<p>Criterion 3.2.1</p> <p>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.</p>	<p>PA Moderate</p>	<p>Initial interRAI assessments have been completed within the required timeframes for five rest home residents. The ACC respite resident does not require interRAI assessments. InterRAI reassessments have not been completed within required timeframes for the five permanent residents. Initial long-term care plans have been developed within the required timeframes for five of the six files reviewed. Long-term care plans, activity care plans, and short-term care plans have not been reviewed as required.</p>	<p>i). Long term care plan and activity plan evaluations have not occurred within required timeframes for five of six files reviewed.</p> <p>ii). Two short term care plans have not been reviewed or closed for between three and four months.</p>	<p>i). Ensure long term care plan and activity plan evaluations occur at least six monthly.</p> <p>(ii). Ensure short term care plans are evaluated at least weekly and either closed when resolved or transferred to the long-term care plan.</p> <p>60 days</p>
<p>Criterion 3.2.5</p> <p>Planned review of a person's care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;</p>	<p>PA Moderate</p>	<p>The policy refers to a registered nurse being responsible for assessments and documentation of care plans. There was evidence of assessment updates and evaluations conducted for some residents with changes to care plans made prior to 3 March 2022. Re-assessments, care plan updates and review of residents activity</p>	<p>i). One rest home resident who sustained skin tears and required hospital admission did not have a care plan updated to include interventions to support pain management, wound management, and short-term mobility changes.</p>	<p>i). Ensure that all acute changes to care requirements are documented in either a short or long-term care plan.</p> <p>ii). Ensure clinical assessments are</p>

<p>(b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.</p>		<p>plans were evidenced to be inconsistent between December 2021 and 10 March 2022. Assessments and care plan reviews have not occurred since 10 March 2022. Healthcare assistants identify clinical concerns and report to the non-clinical facility manager.</p>	<p>ii). Unqualified staff are undertaking clinical assessments. iii). Evaluations of care plans and activities plans undertaken by a previous registered nurse, did not consistently reflect whether goals have been met or not met.</p>	<p>undertaken by qualified staff iii). Ensure that care plan and activity plan evaluations reflect whether goals have been met or not. 60 days</p>
<p>Criterion 3.4.2 The following aspects of the system shall be performed and communicated to people by registered health professionals operating within their role and scope of practice: prescribing, dispensing, reconciliation, and review.</p>	<p>PA Moderate</p>	<p>All medications including over the counter medications have been prescribed by a GP. Indications for use are not always documented for as required medications Administration of medications is completed by HCAs. Controlled drugs are checked six monthly by a pharmacist. Since the last RN left the facility, weekly controlled drug checks have been undertaken by two care staff. Health care assistants assess residents for as required pain relief medication.</p>	<p>i). Three of ten medication files reviewed did not include indications for use for as required medicines. ii). The weekly controlled drug check has not been completed by a registered nurse. iii). Clinical assessments prior to administration of 'as required' controlled drugs, has not been undertaken by a registered nurse.</p>	<p>i). Ensure all as required medications have indications for use recorded. ii). Ensure at least one of the two staff completing the weekly controlled drug check is a registered nurse. iii). Ensure that all clinical assessments for as required pain relief medication including controlled drugs, is</p>

				undertaken by a registered nurse. 30 days
<p>Criterion 3.4.3</p> <p>Service providers ensure competent health care and support workers manage medication including: receiving, storage, administration, monitoring, safe disposal, or returning to pharmacy.</p>	PA Moderate	The medication policy states staff involved with medication administration complete medication competencies annually. Three of six medication competent staff have current competencies. The facility does not have a registered nurse to review annual competencies. Eye drops are dated on opening however, these are not always discarded in accordance with manufacturer guidelines.	<p>i). Three medication competent staff are due to have medication competencies reviewed.</p> <p>ii). Two of three eyedrops in current use were past the expiry date.</p>	<p>i). Ensure all medication competent staff have competencies reviewed annually by suitably qualified staff.</p> <p>ii). Ensure all eyedrops in current use are discarded as per manufacturers guidelines.</p> 60 days
<p>Criterion 3.5.4</p> <p>The nutritional value of menus shall be reviewed by appropriately qualified personnel such as dietitians.</p>	PA Low	There is a four-week winter and summer menu. The kitchen manager stated the menu has changed over the last two years. The 4-week winter menu is due for review however this has not been scheduled. The summer menu is still in use but has not been reviewed for over two years	The summer menu has not been reviewed in over two years. The winter menu is due for review	<p>Ensure the winter and summer menus are reviewed at least two yearly</p> 180 days
<p>Criterion 4.1.1</p> <p>Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples' cultures and supports</p>	PA Low	A preventative maintenance schedule is documented. The maintenance person checks the maintenance request book daily when on site and responds to requests. Test and tag of electrical equipment has been completed for some items as indicated.	<p>i). The preventative maintenance schedule has not been implemented</p> <p>ii). Not all test and tag of electrical equipment can be evidenced as occurring annually.</p>	<p>i). Ensure preventative maintenance is completed as scheduled.</p> <p>ii). Ensure test and tag of electrical items is completed annually.</p>

cultural practices.			iii). Medical devices and equipment are overdue for checking and calibration.	iii). Ensure that all medical equipment is checked and calibrated on an annual basis. 90 days
Criterion 4.2.3 Health care and support workers shall receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Low	Staff receive information on how to respond to emergencies. This training begins during their orientation and continues six monthly. The fire extinguishers and fire hoses were last checked by Wormald staff over one year ago. The facility manager is aware that this was missed at their last Building Warrant of Fitness inspection and has contacted Wormald to request that they return to the facility to complete this aspect of their building warrant of fitness.	Fire extinguishers and fire hoses have not been checked for over one year.	Ensure all fire equipment is checked a minimum of annually. 90 days
Criterion 4.2.4 Service providers shall ensure health care and support workers are able to provide a level of first aid and emergency treatment appropriate for the degree of risk associated with the provision of the service.	PA Moderate	Four staff hold current first aid certificates and eight staff hold an expired first aid certificate. The facility manager reported that those staff with an expired certificate have been booked to attend a course.	A staff member with a current first aid certificate is not always available.	Ensure there is a first aid trained staff available 24 hours a day, seven days a week. 60 days
Criterion 5.2.1 There is an IP role, or IP personnel, as is appropriate for the size and the setting of the service provider, who shall: (a) Be responsible for	PA Moderate	There is an infection control coordinator position description. The service does not currently have a registered nurse employed at the facility. The non-clinical facility manager has assumed the role of infection prevention coordinator, however, has not the experience or clinical knowledge to	i). The person currently responsible for infection control has not completed training or has the experience and clinical knowledge to support the role. ii). The procurement of	i). & ii). Ensure a suitably qualified person oversees the infection prevention programme, and procurement of supplies

<p>overseeing and coordinating implementation of the IP programme;</p> <p>(b) Have clearly defined responsibility for IP decision making;</p> <p>(c) Have documented reporting lines to the governance body or senior management;</p> <p>(d) Follow a documented mechanism for accessing appropriate multidisciplinary IP expertise and advice when needed;</p> <p>(e) Receive continuing education in IP and AMS;</p> <p>(f) Have access to shared clinical records and diagnostic results of people.</p>		<p>support this role. The facility manager is collating monthly data and liaising with the DHB and the GP regarding infection prevention and covid planning and management. The service has access to an aged care infection prevention specialist from the DHB.</p>	<p>infection control supplies does not have currently have clinical oversight.</p>	<p>90 days</p>
<p>Criterion 5.2.2</p> <p>Service providers shall have a clearly defined and documented IP programme that shall be:</p> <p>(a) Developed by those with IP expertise;</p> <p>(b) Approved by the governance body;</p> <p>(c) Linked to the quality improvement programme; and</p> <p>(d) Reviewed and reported on annually.</p>	<p>PA Low</p>	<p>The infection prevention programme has been developed by an external consultant. Policies include the requirement for an annual review of all infections. An annual review was evidenced for 2020 but not for 2021.</p>	<p>The annual infection data for 2021 has not reviewed or reported.</p>	<p>Ensure the annual infection review is completed for 2021</p> <p>180 days</p>

<p>Criterion 5.5.3</p> <p>Service providers shall ensure that the environment is clean and there are safe and effective cleaning processes appropriate to the size and scope of the health and disability service that shall include:</p> <p>(a) Methods, frequency, and materials used for cleaning processes;</p> <p>(b) Cleaning processes that are monitored for effectiveness and audit, and feedback on performance is provided to the cleaning team;</p> <p>(c) Access to designated areas for the safe and hygienic storage of cleaning equipment and chemicals. This shall be reflected in a written policy.</p>	<p>PA Moderate</p>	<p>Policy and procedures include methods, frequency, and monitoring of cleaning schedules. Kitchen cleaning schedules identified inconsistencies</p>	<p>i). Kitchen cleaning had not been consistently completed and unused equipment and floors were visibly soiled.</p> <p>ii). Dining room chairs were visibly soiled and had not been cleaned as scheduled.</p> <p>iii). The skirting and wall coverings in the staff toilet have separated and are unable to be effectively cleaned.</p>	<p>i & ii). Ensure cleaning of dining chairs and kitchen floors and equipment are cleaned as scheduled.</p> <p>iii). Repair surfaces in the staff toilet to enable effective cleaning.</p> <p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

As above, criterion can be linked to the relevant subsection by looking at the code. For example, a Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

No data to display

End of the report.