

# Heartland Care Limited - New Vista

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## Introduction

This report records the results of a Certification 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 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:** Heartland Care Limited

**Premises audited:** New Vista

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

**Dates of audit:** Start date: 18 October 2023      End date: 19 October 2023

**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:** 53

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

New Vista Home and Hospital provides rest home and hospital services for up to 60 residents. There have been changes to the management of the service since the previous audit with the appointments of a new facility manager and clinical manager.

This certification audit was conducted against the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 and the contracts with Te Whatu Ora – Health New Zealand Whanganui (Te Whatu Ora Whanganui). The process included a pre-audit assessment of policies and procedures, a review of residents’ and staff files, observations, and interviews with residents and whānau, a governance representative, management, staff, and a general practitioner.

The facility is managed by an experienced manager supported by an experienced clinical services manager who has clinical oversight of the facility two days per week. Residents and whānau were complimentary of the care provided.

Significant improvements were identified during this audit related to partnerships with Pasifika communities, quality and risk activities, evaluation of ethnicity data to support equity, individualised care planning, staff orientation, staff training and competencies, performance appraisals for staff, infection prevention and antimicrobial stewardship, and restraint management.

## Ō tatou motika | Our rights

<p>Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people’s rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.</p>		<p>Some subsections applicable to this service partially attained and of low risk.</p>
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New Vista Home and Hospital provided an environment that supported residents’ rights. Staff demonstrated an understanding of residents’ rights and obligations. There was a health plan that encapsulated care specifically directed at Māori that endorses Te Whare Tapa Whā model of care. New Vista Home and Hospital worked collaboratively with internal and external Māori supports to encourage a Māori worldview of health in service delivery. Māori were provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake (self-determination) and this was confirmed by Māori residents and staff interviewed.

There was also a health plan in place to support staff caring for residents of Pasifika origin with an appropriate model of care (Fonofale) available for use. There were Pasifika residents and staff in New Vista Home and Hospital at the time of the audit.

Residents and their whānau were informed of their rights according to the Code of Health and Disability Services Consumers’ Rights (the Code) and these were upheld. Residents were safe from abuse and were receiving services in a manner that respected their dignity, privacy, and independence. Care plans accommodated the choices of residents and/or their whānau. There was evidence that residents and their whānau were kept well informed.

Residents and their whānau received information in an easy-to-understand format and were included when making decisions about care and treatment. Open communication was practiced. Interpreter services were provided as needed. Whānau and legal representatives participated in decision-making that complied with the law. Advance directives were followed wherever possible.

Complaints were addressed in a timely manner and resolved promptly and effectively in collaboration with all parties involved.

## Hunga mahi me te hanganga | Workforce and structure

Includes 5 subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation is governed by two owners who are directors of Heartland Care Limited. The governing body is accountable for the delivery of a quality service that is inclusive of, and sensitive to, the cultural needs of Māori. Both directors are suitably experienced and qualified in governance and have completed education in cultural awareness, Te Tiriti o Waitangi and health equity.

Planning ensures the purpose, values, direction, scope, and goals for the organisation are defined. Service performance is monitored and reviewed. There are quality and risk management processes in place. Residents and whānau provide regular feedback on services. The quality and risk process includes collection of quality improvement data. Adverse events are documented and followed up appropriately. The service complies with statutory and regulatory reporting obligations.

Staff are appointed using current good practice. Staff are experienced. Staffing levels are sufficient to provide clinically and culturally appropriate resident care.

Residents' information is accurately recorded, securely stored, was not on public display, or accessible to unauthorised people.

## Ngā huarahi ki te oranga | Pathways to wellbeing

Includes 8 subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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When residents were admitted to New Vista Home and Hospital a person-centred and whānau-centred approach was adopted. Relevant information was provided to the potential resident and their whānau.

The service worked in partnership with the residents and their whānau to assess, plan and evaluate care. Care plans were in place for all residents.

Residents were supported to maintain and develop their interests and participate in meaningful community and social activities suitable to their age and stage of life.

Medicines were safely managed and administered by staff who had been assessed as competent to do so.

The food service met the nutritional needs of the residents with special cultural needs catered for. Food was safely managed.

Residents were transitioned or transferred to other health services as required.

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

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

Some subsections applicable to this service partially attained and of low risk.

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical and biomedical equipment has been checked and tested as required. External areas are accessible, safe, provide shade and seating, and meet the needs of tāngata whaikaha (people with disabilities).

Staff were trained in civil defence procedures and use of emergency equipment and supplies. Staff, residents and whānau interviewed understood emergency and security arrangements. Security is maintained.

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

Includes 5 subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.

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

A suite of infection prevention and control and antimicrobial stewardship policies and procedures were in place. New Vista Home and Hospital has an approved infection control and pandemic plan. Staff demonstrated good principles and practice around infection control. Staff, residents, and whānau were familiar with the pandemic/infectious diseases response plan.

Aged care-specific infection surveillance was undertaken.

The environment supported the prevention and transmission of infections. Waste and hazardous substances were managed. There were safe and effective cleaning and laundry services in place.

## Here taratahi | Restraint and seclusion

Includes 4 subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people’s dignity and mana are maintained.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The policy in place for New Vista Home and Hospital promotes restraint elimination. There were 14 residents using restraints at the time of audit, all of whom had a consent for restraint in place. A restraint coordinator who is a registered nurse manages the process.



## 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	7	6	2	0
Criteria	0	145	0	15	12	5	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.

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

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

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	<p>FA</p>	<p>New Vista Home and Hospital (New Vista) provided an environment that supports residents’ rights. There was a health plan in place that was specifically directed at Māori. Staff have access to a culturally appropriate model of care to guide culturally safe services which can be utilised, but use of this was not evident in care plans for Māori residents in the service (refer criterion 3.2.3).</p> <p>The service works collaboratively with internal and external Māori supports to encourage a Māori world view of health in service delivery. Māori were provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake (self-determination), and this was confirmed by Māori residents and staff interviewed. The service can access support through a kaumatua from Te Whatu Ora Whanganui who is also a member of the Ratana Church.</p> <p>Policies in place are clear that recruitment will be non-discriminatory, and that cultural fit is one aspect of appointing staff. The service supports increasing Māori capacity by employing more Māori staff</p>

		members across differing levels of the organisation. Ethnicity data is gathered when staff are employed. There were staff who identified as Māori in the service, some of whom were in leadership positions.
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p> <p>Te Tiriti: Pacific peoples acknowledge the mana whenua of 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>	PA Low	<p>New Vista has a Pacific health plan in place, developed with input from cultural advisers, which describes how the organisation will respond to the cultural and spiritual needs of Pasifika residents. The plan documents care requirements for Pacific peoples to ensure equitable and culturally appropriate services, and has a culturally appropriate model of care (Fonofale) to guide culturally safe services. There were residents who identified as Pasifika in the facility during the audit; however, the care plans reviewed of these residents made no reference to their specific cultural needs (refer criterion 3.2.3).</p> <p>New Vista has not yet managed to form partnerships with local Pasifika communities (refer criterion 1.2.5).</p> <p>The staff recruitment policy is clear that recruitment will be non-discriminatory, and that cultural fit is one aspect of appointing staff. The service supports increasing Pasifika capacity by employing more Pasifika staff members across differing levels of the organisation as vacancies and applications for employment permit. Ethnicity data is gathered when staff are employed. There were staff who identified as Pasifika in the service, some of whom are in leadership positions.</p>
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>The Code of Health and Disability Services Consumers' Rights (the Code) was displayed in te reo Māori, English, and New Zealand Sign Language (NZSL) on posters around the facility, with brochures available at the facility entrance and reception. A poster on the Nationwide Health and Disability Advocacy Service was displayed in the entranceway and the reception area, in large print. Staff knew how to access the Code in other languages should this be required.</p> <p>Staff interviewed understood the requirements of the code and the availability of the advocacy service and were seen supporting residents of New Vista in accordance with their wishes. Interviews with whānau who visited regularly, confirmed staff were seen to be respectful and</p>

		<p>considerate of residents' rights. Staff had not, however, received any training on the Code since 2021 (refer criterion 2.3.4).</p> <p>New Vista had a range of cultural diversity in their staff mix, and staff could assist if interpreter assistance was required. New Vista also had access to interpreter services and cultural advisors/advocates for Māori if required. Relationships had been established with the Māori cultural advisor at Te Whatu Ora Whanganui. Seventeen staff employed at New Vista identified as Māori. Signage in te reo Māori was evident all around the facility. New Vista recognised residents' mana motuhake (self-determination).</p>
<p>Subsection 1.4: I am treated with respect</p> <p>The People: I can be who I am when I am treated with dignity and respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake.</p> <p>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.</p>	<p>FA</p>	<p>New Vista supported residents in a manner that was inclusive and respected their identity and experiences. Residents and their whānau, including tāngata whaikaha, confirmed that they received services in a manner that had regard for their dignity, gender, privacy, sexual orientation, spirituality, choices, and independence.</p> <p>Care staff understood what Te Tiriti o Waitangi meant to their practice, with te reo Māori and tikanga Māori being promoted.</p> <p>All staff working at New Vista were educated in Te Tiriti o Waitangi and cultural safety. The staff could speak and learn te reo Māori, with the assistance of staff members and residents who identified as Māori. Documentation in one of the two care plans reviewed of residents who identified as Māori acknowledged the resident's cultural identity and individuality. Documentation in the care plan of one Māori and one Pasifika resident did not acknowledge the resident's cultural identity and individuality (refer criterion 3.2.3).</p> <p>Staff were aware of how to act on residents' advance directives and maximise independence. Residents were assisted to have an advanced care plan in place. Residents verified they were supported to do what was important to them, and this was observed during the audit.</p> <p>Staff were observed to maintain residents' privacy throughout the audit. All residents had a private room. New Vista responded to tāngata whaikaha needs and enabled their participation in te ao Māori.</p>

<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	<p>FA</p>	<p>Employment practices at New Vista included reference checking and police vetting. Policies and procedures outlined safeguards in place to protect people from discrimination; coercion; harassment; physical, sexual, or other exploitation; abuse; or neglect. Workers followed a code of conduct. There has been no training on abuse and neglect since 2021 (refer criterion 2.3.4).</p> <p>Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs of such practice. Policies and procedures were in place that focused on abolishing institutional and systemic racism, and there was a willingness to address racism and do something about it. Residents reported that their property was respected. Professional boundaries were maintained.</p> <p>A holistic model of health at New Vista was promoted. The model encompassed an individualised approach that ensured the best outcomes for all. Twelve residents and six whānau interviewed expressed satisfaction with the care provided at New Vista.</p>
<p>Subsection 1.6: Effective communication occurs</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>Residents and their whānau at New Vista reported that communication was open and effective, and they felt listened to. Information was provided in an easy-to-understand format, in English and te reo Māori. Te reo Māori was incorporated in signage throughout the facility. Interpreter services were available if needed, and staff knew how to access these services if required. Resident and whānau meetings at New Vista were held regularly, in addition to regular contacts with whānau by emails, telephone calls, and the open-door policy of the facility manager (FM). A notification on the notice boards advised when the next resident and whānau meeting would be held.</p> <p>Evidence was sighted of residents communicating with all staff, including the FM. Residents and their whānau, and staff, reported the FM responded promptly to any suggestions or concerns.</p> <p>Changes to residents’ health status were communicated to residents and their whānau in a timely manner. Incident reports evidenced whānau were informed of any events/incidents. Documentation</p>

		supported evidence of ongoing contact with whānau or the resident's enduring power of attorney (EPOA). Evidence was sighted of referrals and involvement of other agencies involved in the resident's care when needed.
<p>Subsection 1.7: I am informed and able to make choices</p> <p>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p> <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>	FA	<p>Residents at New Vista and/or their legal representatives were provided with the information necessary to make informed decisions. They felt empowered to actively participate in decision-making. The nursing and care staff interviewed understood the principles and practice of informed consent.</p> <p>Advance care planning, establishing, and documenting EPOA requirements and processes for residents unable to consent were documented, as relevant, in the resident's record.</p> <p>Staff who identified as Māori assisted other staff to support cultural practice. Evidence was sighted of supported decision-making, being fully informed, the opportunity to choose, and cultural support when a resident had a choice of treatment options available to them.</p>
<p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p> <p>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>	FA	<p>A fair, transparent, and equitable system is in place to receive and resolve complaints that leads to improvements. This meets the requirements of the Code. Information on complaints and the complaints process was available to residents, along with information on advocacy options available to them. Residents and whānau interviewed understood their right to make a complaint and knew how to do so.</p> <p>Documentation sighted for two complaints received in the last 12 months showed that the complaints had been addressed or were in the process of being addressed. One of the complaints was closed with the complainants having been informed of the outcome of their complaint. One complaint remains open but is being addressed appropriately and in a timely manner.</p> <p>There have been no complaints from Māori in the service but there are</p>

		<p>processes in place to ensure complaints from Māori are managed in a culturally appropriate way (e.g., through the use of culturally appropriate support, hui, and tikanga practices specific to the resident or the complainant).</p> <p>There had been no complaints received from external sources since the previous audit.</p>
<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>PA Moderate</p>	<p>The two directors of Heartland Care Limited assume accountability for service delivery. Policies in place for Māori and Pasifika support meaningful inclusion of Māori and Pasifika in governance activities, honouring Te Tiriti o Waitangi and being focused on improving outcomes for Māori, Pasifika, and tāngata whaikaha. Policies and procedures also ensure compliance with legislative, contractual, and regulatory requirements. Both of the directors of Heartland Care Limited have undertaken the e-learning education on Te Tiriti, health equity, and cultural safety provided by Manatū Hauora (Ministry of Health). Meaningful Māori representation at governance level is achieved through policy and procedure which is supplied from a contracted provider with extensive experience in aged-care; they have been written with input from Māori.</p> <p>Equity for Māori, Pasifika and tāngata whaikaha is addressed through the policy documentation and enabled through choice and control over supports and the removal of barriers that prevent access to information (eg, bilingual signage, information in other languages for the Code of Rights, and large print where applicable).</p> <p>New Vista has a business plan in place which outlines the organisation’s structure, purpose, values, scope, direction, performance, and goals. The plan is monitored, reviewed, and evaluated at defined intervals. Policies are in place to support practices to improve equitable outcomes for Māori, Pasifika and tāngata whaikaha. Staff training on cultural safety has taken place and this includes Te Tiriti o Waitangi, tikanga practices and use of te reo Māori. Ethnicity data is being collected but this is not evaluated to support equity (refer criterion 2.2.8).</p> <p>Governance commits to quality and risk via policy, procedures, and</p>

	<p>processes but there is no feedback mechanism in place from the management team at New Vista to governance (refer criterion 2.1.4). The FM at New Vista is an enrolled nurse (EN) with significant aged-care and management experience. Clinical governance is in place, but this is not sufficient to maintain safe clinical care (refer criteria 3.2.3, 3.2.4, 3.2.5, and subsections 5 and 6), nor is it appropriate to the size and complexity of the organisation (refer criteria 2.1.11). Clinical governance is currently being supported by a clinical nurse manager (CNM) who is a registered nurse (RN), who oversees that role two days per week.</p> <p>The FM and CNM confirmed knowledge of the sector, regulatory and reporting requirements, and both maintain currency within the field.</p> <p>Internal quality data (eg, adverse events, complaints, infections, antibiotic use, internal audits, and restraint use) is collected and with corrective action completed where deficits are identified. These are not being reported to governance level to promote governance leadership of the system (refer criterion 2.1.4).</p> <p>Residents and whānau contribute to quality improvement through the ability to give feedback at meetings and in surveys. Residents' and whānau satisfaction surveys and general resident and whānau meetings showed a high level of satisfaction with the services provided. Residents and whānau interviewed, including those who identify as Māori or Pasifika, verbally reported a high level of satisfaction with the services being delivered, confirming these were being delivered in a culturally appropriate way.</p> <p>The service holds contracts with Te Whatu Ora Whanganui for aged-related residential care (AARC) at rest home and hospital levels. It also holds contracts with Te Whatu Ora Whanganui for short-term care (respite), Long Term Support-Chronic Health Conditions (LTS-CHC), intermediate care (nexus between the public hospital and the resident's home), and for care of the chronically medically ill. A contract is held with Whaikaha (Ministry of Disabled People) for Young People Disabled (YPD). Fifty-three (53) residents were receiving services on the first day of audit. Twenty-four (24) residents were receiving services at rest home level, 22 at hospital level, three receiving intermediate care, and four under the Whaikaha YPD contract. No residents were receiving services under the respite, LTS-CHC, or the chronically</p>
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		medically ill contracts.
<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>	PA Low	<p>The FM described the processes for the identification, documentation, monitoring, review, and reporting of risks, including health and safety risks, and development of mitigation strategies. The directors and FM at New Vista are committed to quality and risk via its quality and risk management plan, and through policy. Policies reviewed covered all necessary aspects of the service and contractual requirements and were current.</p> <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents/accidents/hazards (including the monitoring of clinical incidents such as falls, pressure injuries, infections, wounds, and medication errors), complaints, audit activities, and policies and procedures. Staff document adverse and near miss events in line with the National Adverse Event Reporting Policy. Relevant corrective actions are developed and implemented to address any shortfalls. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans were developed, and any corrective actions followed up in a timely manner. Not all internal audits are completed and on the ones that were, corrective actions are not always followed up (refer criterion 2.2.1).</p> <p>Quality data is collected but is not communicated or discussed with either governance or the staff (refer criterion 2.1.1 and 2.2.1); this was confirmed by the governance representative and staff interviewed. Organisational practices to improve health equity is occurring through the Māori and Pasifika health plans and through staff who identify as Māori or Pasifika. Management staff were aware of the outcomes from quality activities. Ethnicity data was being collected by the service but there had been no analysis of organisational practices and no evaluation of the data to promote health equity for service users (refer criterion 2.2.8).</p> <p>The FM understood and has complied with essential notification reporting requirements. There have been three section 31 notifications completed in the last 12 months. These related to the change of the</p>

		FM, the change of the CNM, and one due to an unstageable pressure injury (non-facility acquired).
<p>Subsection 2.3: Service management</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>	PA Moderate	<p>There is a documented and implemented process for determining staffing levels and skill mix to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). This is being adhered to with the exception of clinical management oversight (refer 2.1.11). The facility adjusts staffing levels to meet the changing needs of residents. Staff reported there were adequate staff numbers to complete the work allocated to them. Residents and whānau interviewed supported this. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital. Position descriptions reflected the role of the respective position and expected behaviours and values.</p> <p>There was no plan in place for education of staff and there had been little education delivered in 2022-2023 (refer criterion 2.3.4). Education relevant to the care of Māori and Pasifika has been delivered in 2023. Related competencies have been assessed in 2023 for medication management (including syringe driver management), moving and handling, civil defence, and cultural safety competency. Competencies in fire and emergency management were not completed in 2022 or 2023 (refer criterion 4.2.3). Caregiving staff have access to a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreements with Te Whatu Ora Whanganui.</p> <p>The collecting and sharing of high-quality Māori health information across the service is through policy and procedure, by virtue of the number of staff within the service who identify as Māori (some of whom are te reo Māori speakers), resident and whānau engagement, and through staff cultural education.</p> <p>Staff wellbeing policies and processes are in place and staff reported feeling well supported and safe in the workplace. Staff have access to independent counselling services.</p>

<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	<p>PA Low</p>	<p>Human resources recruitment practices are based on good employment practice and relevant legislation. There are job descriptions in place for all positions, with the exception of infection prevention and control (IPC) and restraint (refer criteria 5.2.1 and 6.1.3). The job descriptions that are in place include outcomes, accountability, responsibilities, authority, and functions to be achieved in each position.</p> <p>Qualifications are validated prior to employment. Thereafter, a register of annual practising certificates (APCs) is maintained for RNs, ENs, and associated health contractors (the general practitioner (GP), pharmacists, podiatrist, and dietitian).</p> <p>A sample of nine staff records were reviewed. This evidenced implementation of the recruitment process, the provision of employment contracts, reference checking, and police vetting. Completed induction and orientation was not evident in all files (refer criterion 2.4.4), and staff performance has not been reviewed and discussed at regular intervals (refer criterion 2.4.5); this was confirmed through documentation sighted and interviews with staff. Staff reported that if they have had a performance appraisal, they have input into the performance appraisal process, and that they can set their own goals.</p> <p>Ethnicity data for staff is recorded and used in line with health information standards. Staff information is secure and accessible only to those authorised to use it.</p> <p>Debrief for staff is outlined in policy; staff interviewed confirmed the opportunity for debrief and that support is available to them.</p>
<p>Subsection 2.5: Information</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</p>	<p>FA</p>	<p>New Vista maintained quality records that complied with relevant legislation, health information standards and professional guidelines. Information held electronically was username and password protected. Any paper-based records were held securely, were only available to authorised users, and were held only for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>All necessary demographic, personal, clinical, and health information</p>

<p>accurate, sufficient, secure, accessible, and confidential.</p>		<p>was fully completed in the residents' files sampled for review. Clinical notes were current, integrated, and legible, and met current documentation standards. Consent was sighted for data collection. Data collected included ethnicity data.</p> <p>New Vista is not responsible for the National Health Index registration of people receiving services.</p>
<p>Subsection 3.1: Entry and declining entry</p> <p>The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p> <p>As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from 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>FA</p>	<p>Residents were welcomed into New Vista when they had been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) agency as requiring the level of care New Vista provided and had chosen New Vista to provide the services they require.</p> <p>Whānau interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission, including for residents who identified as Māori. The files reviewed met contractual requirements. New Vista collected ethnicity data on entry and decline rates. This included specific data for entry and decline rates for Māori, but this was not being reported to governance level (refer criterion 2.1.4).</p> <p>Where a prospective resident had been declined entry, there were processes for communicating the decision to the person and/or whānau.</p> <p>New Vista had developed meaningful partnerships with local Māori to benefit Māori individuals and their whānau. The facility can access support from Māori health practitioners, traditional healers, and other organisations by contacting the Māori cultural advisor at Te Whatu Ora Whanganui. When admitted, residents had a choice over who would oversee their medical requirements. Whilst most chose the main medical provider to New Vista, several residents had requested another provider to manage their medical needs, and this had been facilitated.</p>
<p>Subsection 3.2: My pathway to wellbeing</p>	<p>PA</p>	<p>The team at New Vista worked in partnership with the resident and</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>Moderate</p>	<p>their whānau to support the resident's wellbeing. Ten residents' files were reviewed: six hospital files and four rest home files. These files included residents who were receiving care under an intermediate care contract, residents who were receiving care under a young person with a disability contract, and residents receiving care under the ARRC contract. Files reviewed included residents admitted with a pressure injury (4) or had a facility-acquired pressure injury (7), residents who had experienced a recent fall, residents with reactive behaviours that challenge, residents with several co-morbidities, residents who identified as Māori or Pasifika, and residents who required restraint.</p> <p>The files reviewed verified that a care plan was developed by an RN following a comprehensive assessment, including consideration of the person's lived experience, cultural needs, values, and beliefs, and considers wider service integration, where required. Assessments were based on a range of clinical assessments and included resident and whānau input (as applicable). Timeframes for the initial assessment, GP input, initial care plan, long-term care plan, short-term care plans, and review/evaluation timeframes met contractual requirements. Policies and processes were in place to ensure tāngata whaikaha and whānau participate in New Vista's service development, deliver services that give choice and control, and remove barriers that prevent access to information. Service providers understood the Māori constructs of oranga and had implemented a process to support Māori and whānau to identify their pae ora outcomes in their care plan. The support required to achieve this was communicated, and understood; however, not always documented (refer criterion 3.2.3).</p> <p>Care at times was not always being provided as per resident need (refer criterion 3.2.4). Acute events, for example, post fall assessments and neurological observations were managed in accordance with best practice guidelines. A resident who had recently deteriorated and had a marked change in need, had no updated documentation to reflect the change in need and the plan for the resident's care. However, progress notes and observations verified the care was being provided. A resident with a pressure injury had no pressure relieving mattress in place. This was verified by reviewing documentation, sampling residents' records, interviews, and from observation.</p> <p>Management of any specific medical conditions was not well</p>
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		<p>documented (refer criterion 3.2.3). There was inconsistent evidence of systematic monitoring (refer criterion 3.2.4), and irregular evaluation of responses to planned care (refer criterion 3.2.5). Where progress was different from that expected, changes were often not made to the care plan (refer criterion 3.2.3), although changes did include collaboration with the resident and their whānau. These are areas identified as requiring improvement. Residents and their whānau confirmed active involvement in the care planning process, including young residents with a disability.</p> <p>Interviews with four whānau of other residents expressed a high degree of satisfaction with the care provided at New Vista. The residents and their whānau were actively involved in planning the residents' care and any ongoing discussions.</p> <p>An interview with the GP expressed concerns around lack of continuity in care and communication difficulties at New Vista. The staff on duty were often unaware of residents' problems as they either had not been on duty or had not been updated regarding residents' status. Interviews verified the CNM only worked two morning duties (refer criterion 2.1.11), the RN on duty was new, and was unfamiliar with a number of systems. Residents' care plans were not up to date. Systems in place did not support enabling continuity of care. On the day of audit the FM and the GP discussed the GPs concerns, and proposed action to be taken.</p>
<p>Subsection 3.3: Individualised activities</p> <p>The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.</p>	<p>FA</p>	<p>The activity assistants at New Vista (two daily, five days a week) provided an activities programme that supported residents in maintaining and developing their interests, tailored to their ages and stages of life. The younger residents were enabled to participate in activities that were of interest to them.</p> <p>Activity assessments and plans identified individual interests and considered the person's identity. Individual and group activities reflected residents' goals and interests and their ordinary patterns of life and included normal community activities. The activities programme evidenced a diverse range of activities being provided. Interviews with residents and their whānau identified there was always a range of</p>

		<p>activities happening at New Vista. Opportunities for Māori and whānau to participate in te ao Māori were facilitated. Matariki, Waitangi Day and Māori Language Week were celebrated.</p> <p>Due to COVID-19 restrictions, a number of visits by local school and pre-school groups had been stopped and it is taking a while for these contacts to be reestablished due to an ongoing perceived risk. However, entertainment groups visit weekly. Staff encourage and facilitate discussions with residents during daily activities. Residents and whānau meetings had recommenced this year. Residents and their whānau participated in evaluating and improving the programme. Meeting minutes, satisfaction survey results, and interviews evidenced a high degree of satisfaction with the activities programme being provided.</p> <p>The facility had a van that enabled residents to attend weekly outing to places of interest.</p>
<p>Subsection 3.4: My medication</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>FA</p>	<p>The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was seen on the day of the audit. All staff who administer medicines were assessed as competent to perform the function they manage. There was a process in place to identify, record, and document residents' medication sensitivities, and the action required for adverse events.</p> <p>Medications were supplied to the facility from a contracted pharmacy. Medication reconciliation occurred. All medications sighted were within current use-by dates.</p> <p>Medicines were stored safely, including controlled drugs. The required stock checks were completed. The medicines stored were within the recommended temperature range. There were no vaccines stored on site. Processes were in place to address medication errors (refer criterion 2.3.4).</p> <p>Prescribing practices met requirements. The required three-monthly GP review was recorded on the medicine chart. Standing orders were used at New Vista and the relevant guidelines were in place.</p>

		<p>Safe self-administration of medication was facilitated for one resident who self-administered medication at New Vista.</p> <p>Residents, including Māori residents and their whānau, were supported to understand their medications.</p> <p>Over-the-counter medication and supplements were considered by the prescriber as part of the person's medication.</p>
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	<p>FA</p>	<p>The food service provided at New Vista was in line with recognised nutritional guidelines for older people. The menu was reviewed by a qualified dietitian on 10 January 2023. Recommendations made at that time had been implemented.</p> <p>The service operated with an approved food safety plan and registration. A verification audit of the food control plan was undertaken at New Vista on 10 May 2022. One area requiring corrective action was identified, regarding a requirement to record the cooling temperature of mince. This was addressed and the plan was verified for 18 months. The plan is due for re-audit on 10 November 2023.</p> <p>Each resident had a nutritional assessment on admission to the facility. Their personal food preferences, any special diets, and modified texture requirements were accommodated in the daily meal plan. All residents had opportunities to request meals of their choice and the kitchen would address this.</p> <p>Interviews, observations, and documentation verified residents were satisfied with the meals provided. Evidence of residents' satisfaction with meals was verified by residents and whānau interviews, satisfaction surveys, and resident and whānau meeting minutes. This was supported during the audit when residents responded favourably regarding the meals provided on these days. Māori and whānau had menu options available that were culturally specific to te āo Māori.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</p> <p>The people: I work together with my service provider so they</p>	<p>FA</p>	<p>Transfer or discharge from New Vista was planned and managed safely to cover current needs and mitigate risk. The plan was developed with coordination between services and in collaboration with</p>



<p>know what matters to me, and we can decide what best supports my wellbeing when I leave the service.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.</p>		<p>the resident and their whānau. The whānau of a resident who was recently transferred reported that they were kept well-informed throughout the process.</p> <p>Whānau were advised of their options to access other health and disability services, social support, or kaupapa Māori services if the need was identified.</p>
<p>Subsection 4.1: The facility</p> <p>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>	<p>FA</p>	<p>Appropriate systems are in place to ensure the residents' physical environment and facilities (internal and external) are fit for their purpose, well maintained and that they meet legislative requirements. A planned maintenance schedule includes electrical testing and tagging, resident equipment checks, and calibrations of biomedical equipment. Monthly hot water tests are completed for resident areas; these were sighted and were all within normal limits.</p> <p>The building has a building warrant of fitness which expires on 22 June 2024. There are currently no plans for further building projects requiring consultation, but the directors of Heartland Care Limited were aware of the requirement to consult and co-design with Māori if this was envisaged.</p> <p>The environment was comfortable and accessible. Corridors have handrails promoting independence and safe mobility. Personalised equipment was available for residents with disabilities to meet their needs and residents were observed to be safely using these. Spaces are culturally inclusive and suited the needs of the resident groups, including tāngata whaikaha. Lounge and dining facilities meet the needs of residents, and these are also used for activities. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility, including for staff and visitors. All rooms, bathrooms and communal areas have appropriately situated call bells. There are external areas within the facility for leisure activities with appropriate seating and shade.</p> <p>Residents' rooms are appropriate for their purpose. Rooms for</p>

		<p>residents receiving hospital level care are spacious and allowed room for the use of mobility aids and moving and handling equipment. Rooms were personalised according to the resident's preference. All rooms have a window allowing for natural light with safety catches for security. Electric heating is provided in the facility which can be adjusted depending on seasonality and outside temperature.</p> <p>Residents and whānau interviewed were happy with the environment, including heating and ventilation, privacy, and maintenance. Care staff interviewed stated they have adequate equipment to safely deliver care for residents.</p>
<p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p>	<p>PA Low</p>	<p>The recently reviewed fire evacuation plan was approved by Fire and Emergency New Zealand (FENZ) on 8 July 2023 and the requirements of this are reflected in the Fire and Emergency Management Scheme. The plan requires that a cell fire evacuation drill be held six-monthly; the most recent drill was held on 27 June 2023. The facility is sprinklered and has wired smoke alarms in place. Also in place are fire hoses and extinguishers and these were checked in April 2023. Training for staff on fire and emergency management has not occurred in 2022 or 2023 (refer criterion 4.2.3).</p> <p>Disaster and civil defence plans and policies direct the facility in their preparation for disasters and described the procedures to be followed. Adequate supplies for use in the event of a civil defence emergency meet the National Emergency Management Agency recommendations for the region. Staff have been trained on civil defence in 2023 and knew what to do in a civil defence emergency.</p> <p>The rosters reviewed evidenced that there is a first aid certified staff member on duty 24/7. Information on emergency and security arrangements is provided to residents and their whānau on entry to the service. All staff were noted to be wearing name badges and uniforms during the audit.</p> <p>Call bells alert staff to residents requiring assistance and these were noted to be accessible and within reach of residents and staff. Residents and whānau interviewed during the audit reported staff respond promptly to call bells. Appropriate security arrangements are in</p>

		place.
<p><b>Subsection 5.1: Governance</b></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>	PA Low	<p>New Vista had a suite of infection prevention (IP) and antimicrobial stewardship (AMS) measures outlined in its policy documents. The IP and AMS programmes were appropriate to the size and complexity of the service, but activities in relation to IP and AMS were not consistently carried out (refer subsections 5.2 to 5.5).</p> <p>Clinical specialists can access IP and AMS expertise through Te Whatu Ora Whanganui infection prevention and control nurse specialists, and Regional Public Health where clinically indicated.</p> <p>There was no evidence to support that IP and AMS was discussed at governance level, except for the reporting of significant events (refer criterion 5.1.3). Residents with infections have these managed in a stepwise approach with input from nursing staff at New Vista and the resident's GP. Significant infections (e.g., COVID-19 and other transmissible infections) are managed within accepted protocols.</p>
<p><b>Subsection 5.2: The infection prevention programme and implementation</b></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>	PA Moderate	<p>The appointed infection control officer (ICO) at New Vista resigned nine months ago, and a new infection control officer (ICO) at New Vista has only recently been appointed but they have not signed a job description for the role (refer criterion 5.2.1). The IP and AMS programme at New Vista was provided by an external advisory company with expertise in IP and AMS. The programme has been approved by the governing body. The IP and AMS programme at New Vista has not been linked to the quality improvement programme and had not been reviewed and reported annually (refer criteria 5.2.2). The ICO is an RN however as verified at interview had no skills, knowledge, or qualifications for the role; however, they confirmed they have access to the necessary resources and support. The ICO's advice had not been sought when making decisions around procurement relevant to care delivery, facility changes, and policies (refer criterion 5.2.7). There were no changes currently planned in the service that would require consultation with the ICO.</p> <p>The infection prevention and control policies reflecting the requirements</p>

		<p>of the standard were provided by an external advisory company. Cultural advice at New Vista was accessed through the staff who identified as Māori and the cultural advisor. On interview, staff were familiar with policies and were observed following policies and processes correctly. There has been no ongoing infection control education since 2021 (refer criterion 2.3.4). Policies and processes ensured that reusable and shared equipment was appropriately decontaminated using best practice guidelines. Individual use items were discarded after being used. Staff who identified as Māori and speak te reo Māori can provide infection control advice in te reo Māori if needed for Māori accessing services. Educational resources available in te reo Māori were not accessible and understandable for Māori accessing services (refer criterion 5.2.12).</p> <p>The appointed ICO has expertise in te reo Māori and can work in partnership with Māori for the protection of culturally safe practice that acknowledges Te Tiriti o Waitangi.</p> <p>The pandemic/infectious diseases response plan was documented and had been evaluated. There were sufficient resources and personal protective equipment (PPE) available, stocks were sighted, and staff verified their availability at the interview. Staff had not been trained in their use (refer criterion 2.3.4). Residents and their whānau were educated about infection prevention in a manner that met their needs.</p>
<p>Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation</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>	PA Low	<p>New Vista has a documented AMS programme in place. The AMS programme has been developed using the evidence-based expertise of an external advisory company and has been approved by the governing body. Policies and procedures were in place which complied with evidence-informed practice. The effectiveness of the AMS programme has not been evaluated by monitoring the quality and quantity of antimicrobial use. Evidence was not sighted of a reduction in the use of antibiotics and the identification of ongoing areas for improvement (refer criterion 5.3.3).</p>
<p>Subsection 5.4: Surveillance of health care-associated infection</p>	PA	<p>New Vista undertook surveillance of infections appropriate to that</p>

<p>(HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p>	<p>Moderate</p>	<p>recommended for long-term care facilities and this was in line with priorities defined in the infection control programme. New Vista used standardised surveillance definitions to identify and classify infection events that relate to the type of infection under surveillance.</p> <p>Monthly surveillance data was collated to identify any trends, possible causative factors, and required actions. Results of the surveillance programme were not reported to management, the governing body or shared with staff (refer criterion 5.4.4). Surveillance data does include ethnicity data.</p> <p>Culturally clear processes were in place to communicate with residents and their whānau, and these were documented.</p>
<p>Subsection 5.5: Environment</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.</p> <p>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible.</p> <p>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobial-resistant organisms.</p>	<p>PA Low</p>	<p>A clean and hygienic environment supported the prevention of infection and transmission of antimicrobial-resistant organisms at New Vista. Suitable personal protective equipment was provided to those handling contaminated material, waste, and hazardous substances, and those who perform cleaning and laundering roles. Safe and secure storage areas were available, and staff had appropriate and adequate access, as required. Chemicals were labelled and stored safely within these areas, with a closed system in place. Sluice rooms were available for the disposal of soiled water/waste. Hand washing facilities and liquid hand sanitiser gel dispensers were available throughout the facility.</p> <p>Staff followed documented policies and processes for the management of waste and infectious and hazardous substances.</p> <p>All laundry was laundered on-site, including residents' personal clothing. Policies and processes were in place that identified the required laundering processes, including the limited access to areas where laundry equipment and chemicals were stored. A clear separation for the handling and storage of clean and dirty laundry was sighted. Evidence was sighted of commitment to cultural safety by the separation of items prior to their being laundered.</p> <p>The environment was observed to be clean and tidy. Safe and effective cleaning processes identified the methods, frequency, and materials to be used in cleaning processes. Clear separation of the use of clean</p>

		<p>and dirty items was observed in the cleaning process. Designated access was provided to maintain the safe storage of cleaning chemicals and cleaning equipment. Chemicals were labelled appropriately.</p> <p>Laundry and cleaning processes were monitored for effectiveness. Staff involved were observed to be performing their duties safely.</p> <p>There was no evidence that the ICO has oversight of the facility testing and monitoring programme for the built environment (refer criterion 5.5.5).</p> <p>Residents and their whānau reported that the laundry was managed well, and the facility was kept clean and tidy. This was confirmed through observation.</p>
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>	<p>PA Moderate</p>	<p>The FM and directors of New Vista advised that they are committed to reducing restraint use in the facility; however, restraint use has increased since the last audit from 10 to 14 residents using a restraint. Of these, one was using a vest harness, one a lap belt, and the rest (12) bed rails (refer criterion 6.1.1). There was no assessment or evaluation of restraint being carried out at New Vista to allow alternative options to restraint to be fully considered (refer criteria 6.2.1 and 6.2.7). Restraint is also not being discussed at governance level or included in strategic documentation. Aggregated information on restraint use is not being reported to the board (refer criterion 6.1.4).</p> <p>The restraint coordinator (RC) is a defined role undertaken by a RN. It is in the RC role that they provide support and oversight of restraint use; however, the RC is newly appointed, does not have a job description that outlines the role, and has had minimal education specific to restraint and its use (refer criterion 6.1.3). The CNM and FM were not involved in restraint activities at the service.</p> <p>Restraint elimination and use of alternative interventions is incorporated into relevant policies, including those on procurement processes, clinical trials, and use of equipment. Policies are in place that require the use of restraint to be part of the holistic assessment of the person's care or support plan, but this was not evident in the</p>

		<p>residents' files reviewed (refer criter 3.2.4). Policy or procedure in place informs the delivery of services to avoid the use of restraint, the process of approval and review of de-escalation methods, the types of restraint used, and the duration of restraint used by the service provider but these are not being implemented (refer criterion 6.1.5).</p> <p>For any decision to use or not use restraint, there is a process to involve the resident, their EPOA and/or whānau as part of the decision-making process. This was evidenced in the consent forms on the files of residents using a restraint.</p> <p>Staff have not received any training in 2023 on the management of behaviours that challenge, least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques in either 2022 or 2023 (refer criterion 6.1.6). Restraint protocols are covered in the orientation and training programme of the facility, but this is not being consistently delivered (refer criteria 2.3.4 and 2.4.4). While restraint use is identified as part of the quality programme, audits on restraint use have not been completed (refer criterion 2.2.1) and restraint use is not reported within the organisation (refer criterion 6.1.4).</p>
<p><b>Subsection 6.2: Safe restraint</b></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> <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>PA High</p>	<p>The restraint policy at New Vista outlined appropriate restraints to be used at New Vista; these include bedrails, chair lap belts and 'fall out' chairs as appropriate restraint equipment. A vest harness was being used for one resident and this was not outlined in policy.</p> <p>The restraint register revealed that the number of residents requiring restraint interventions since the last audit had increased from 10 to 14. There was very little evidence in care plans and restraint documentation to show that alternative strategies to restraint had been tried prior to the use of restraint (refer criterion 6.2.1). The frequency and extent of monitoring of people during restraint was to be determined by a registered health professional; however, documentation showed little evidence that restraint was being monitored as per the documented requirements, and staff interviewed agreed that restraint monitoring was not carried out as per the requirements (refer criterion 6.2.2). Restraint monitoring was simplistic</p>

		<p>and did not address people’s cultural, physical, psychological, and psychosocial needs, or wairuatanga/family connections (refer criterion 6.2.3).</p> <p>New Vista continues to maintain a restraint register; the criteria on the restraint register contained enough information to provide a record of restraint use should this be required; however, the restraint committee has not met in 2023 and had not undertaken a six-monthly review of all residents who may be at risk, outlining strategies to be used to prevent restraint being required (refer criterion 6.3.1). In addition to this, restraint was not documented in people’s records in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome of the restraint (refer criterion 6.2.4).</p> <p>There was no evidence of assessment prior to restraint being implemented on any of the records of residents using a restraint. There was little evidence (on the consent form only) to indicate that restraint had been initiated as a last resort, but interventions tried were not outlined (refer criterion 6.2.1). There was no documentation around cultural assessment of the impact of culture on a person using a restraint (refer criterion 6.2.1). Consents for all restraints in use were in the residents’ individual files and these were signed off by the RC, the resident’s EPOA or next of kin, and the resident’s GP.</p> <p>There have been no emergency restraint episodes since the previous audit. Processes for the use of emergency restraint and debrief following emergency restraint is documented in policy.</p> <p>There were no records to show that the use of restraint for individuals had been evaluated.</p>
<p>Subsection 6.3: Quality review of restraint</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</p>	<p>PA High</p>	<p>There was no evidence available to show that the restraint committee had met in 2023. There was no six-monthly review of the use of restraint at New Vista (refer criterion 6.3.1). Restraint data are not reported as part of the clinical reporting structure. There had been no incidents documented related to restraint use.</p> <p>Internal audit for restraint is part of the internal auditing schedule, but this had not been carried out in 2023 (refer criterion 2.2.1). Clinical staff</p>



<p>restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.</p>		<p>have not attended restraint-specific education in 2022 or 2023 (refer criterion 2.3.4) and at interview did not have an acceptable level of knowledge and understanding about safe restraint use and the need to minimise this. Care planning in terms of restraint was minimal in all 14 records (refer criterion 3.2.3). Restraint activity is not reported at any of the staff, RN/EN, quality, or health and safety meetings (refer criterion 2.2.1) and there was no reporting of restraint to governance level (refer criterion 2.1.4).</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.5</p> <p>My service provider shall work in partnership with Pacific communities and organisations, within and beyond the health and disability sector, to enable better planning, support, interventions, research, and evaluation of the health and wellbeing of Pacific peoples to improve outcomes.</p>	PA Low	New Vista has not, as yet, connected to external Pacific communities and organisations, to enable better planning, support, interventions, research, and evaluation of the health and wellbeing of Pacific peoples to improve outcomes for Pasifika residents. Discussions have commenced with a Pasifika elder to see if they are able to provide the support New Vista requires; this was described by management as a ‘work in progress’.	New Vista has not yet connected to external Pacific communities and organisations, to enable better planning, support, interventions, research, and evaluation of the health and wellbeing of Pacific peoples to improve outcomes for Pasifika residents.	<p>Provide evidence that New Vista has connected to external Pacific communities and organisations, to enable better planning, support, interventions, research, and evaluation of the health and wellbeing of Pacific peoples to improve outcomes for Pasifika residents.</p> <p>180 days</p>
<p>Criterion 2.1.11</p> <p>There shall be a clinical governance structure in place that is appropriate to the size</p>	PA Moderate	Clinical governance is in place, but this is not sufficient to maintain safe clinical care, nor is it appropriate to the size and complexity of the	Clinical governance is insufficient to maintain safe clinical care and it is not appropriate for the size and	Provide evidence that clinical governance is being provided full time to support the FM who is not a registered nurse and to

<p>and complexity of the service provision.</p>		<p>organisation. Clinical governance is supported by a clinical nurse manager (CNM) who oversees that role two days per week, working on night duty three days per week. This is also in contravention of the requirement under the ARRC contract (D17.4 ba) that a full-time clinical manager be in place when the FM is not a registered nurse (the FM is an EN). Prior to the end of the audit, the management and governance team recognised that two days per week of clinical governance was insufficient to safely provide the services New Vista provides. An interim solution was put into place to begin immediately to have the CNM on shift in the clinical oversight role five days per week.</p>	<p>complexity of the organisation. The lack of clinical governance in a full-time role is in contravention of the ARRC contract D17.4 ba.</p>	<p>meet the requirements of ARRC contract D17.4 ba.</p> <p>90 days</p>
<p>Criterion 2.1.4 Governance bodies shall evidence leadership and commitment to the quality and risk management system.</p>	<p>PA Low</p>	<p>Governance has a quality and risk management plan in place as well as a suite of policies and procedures to support quality activities. There are, however, no feedback mechanisms in place from the management team at New Vista to report quality activities to governance to assist with the promotion of leadership of quality and risk in the service. There is no reporting of internal audits, adverse events, infections, antimicrobial use, complaints, or restraint use. The service used to have monthly reporting, but this has not happened for some time. The owner stated at</p>	<p>While governance has plans, policies, and procedures in relation to quality and risk activities within the service, there is no reporting of outcomes from quality and risk activities from the management team to governance to promote leadership of the quality and risk system by governance.</p>	<p>Provide evidence that outcomes from quality and risk activities are being reported to governance so that they can provide leadership and oversight of the quality and risk system.</p> <p>180 days</p>

		interview this will be reinstated.		
<p>Criterion 2.2.1</p> <p>Service providers shall ensure the quality and risk management system has executive commitment and demonstrates participation by the workforce and people using the service.</p>	PA Low	<p>Quality data is collected but is not communicated or discussed with either governance or the staff. There is no reporting mechanism from management to governance (refer criterion 2.1.4). Minutes from staff meetings do not evidence any discussion of adverse events, internal audits outcomes, infection prevention and control activities, or restraint use. Staff and the governance representative interviewed confirmed that this information is not currently being shared. Internal audits are not completed as per the schedule and where they are, these are not followed up. Internal audits from April to October 2023 were reviewed; of the 34 audits that were meant to occur, 11 did not take place. Of the internal audits that were completed, 14 evidenced 100% compliance; the remainder had corrective actions identified but, except for one, these were not signed off as completed, nor re-audited if sign-off was not achieved. There was evidence that significant events (e.g., COVID-19 precautions and any potential hazards) were being reported at resident meetings.</p>	<p>There is no evidence of a reporting mechanism to governance or to staff to allow governance and staff to be aware of any quality and risk issues within the service. Minutes from staff meetings do not evidence any discussion of adverse events, internal audits outcomes, infection prevention and control activities, or restraint use. Not all internal audits are being completed as per the schedule or have corrective actions identifying signed off.</p>	<p>Provide evidence that governance and staff have information in relation to quality and risk activities in reports or at staff meetings. Provide evidence that internal audits are being fully completed with appropriate corrective action sign-off.</p> <p>180 days</p>

<p>Criterion 2.2.8</p> <p>Service providers shall improve health equity through critical analysis of organisational practices.</p>	<p>PA Low</p>	<p>Ethnicity data was being collected by the service but there had been no analysis of organisational practices and no evaluation of the data to promote health equity for service users.</p>	<p>There are no processes in place to use ethnicity data to improve health equity through critical analysis of organisational practices.</p>	<p>Provide evidence that there are processes in place to use ethnicity data to improve health equity through critical analysis of organisational practices.</p> <p>180 days</p>
<p>Criterion 2.3.4</p> <p>Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.</p>	<p>PA Moderate</p>	<p>There was no training plan in place at New Vista for 2023. Education has taken place only for civil defence, the code of conduct for staff, nutrition for aged care, and cultural safety, and this has been recorded. An education session on the management of controlled drugs took place following three incidents of medication errors in the facility between June and September 2023. There has been no training on the code of rights, abuse and neglect, care activities, infection control (including PPE use), or restraint.</p>	<p>There has been no system in place over 2022-2023 to identify, plan, and facilitate ongoing learning and development for health care and support workers so that they can provide high-quality safe services.</p>	<p>Provide evidence that there is a system in place to identify, plan, and facilitate ongoing learning and development for health care and support workers so that they can provide high-quality safe services.</p> <p>90 days</p>
<p>Criterion 2.4.4</p> <p>Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>Policy and procedure require that all staff employed are orientated to the service. Not all staff have completed an orientation and induction to the service. Nine files were reviewed; of these, five had commenced employment with New Vista between 2021 and 2023 (others reviewed were staff who had been in the service for some time). Of the five that had commenced employment</p>	<p>Not all staff who had commenced employment between 2021 and 2023 had completed an orientation and induction programme that covered the essential components of the service as required by the service's policy and procedure.</p>	<p>Provide evidence that all staff employed by New Vista have completed an orientation and induction programme that covers the essential components of the service as required by the service's policy and procedure.</p> <p>180 days</p>

		between 2021 and 2023, three had not completed an orientation programme.		
<p>Criterion 2.4.5</p> <p>Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.</p>	PA Low	<p>Policy and procedure require that performance appraisals be conducted annually. Not all staff have received a performance appraisal during the last 12 months. Nine files were reviewed; of these, six staff were due to have had a performance appraisal in the last 12 months (based on their start date), and of these six, only two had completed a performance appraisal with their employer.</p>	<p>Not all staff who were due to have an annual performance appraisal in the last 12 months (based on their start date) have completed a performance appraisal with their employer as required by the service's policy and procedure.</p>	<p>Provide evidence that all staff in the service have had an annual performance appraisal as required by the service's policy and procedure.</p> <p>180 days</p>
<p>Criterion 3.2.3</p> <p>Fundamental to the development of a care or support plan shall be that:</p> <p>(a) Informed choice is an underpinning principle;</p> <p>(b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan;</p> <p>(c) Comprehensive assessment includes consideration of people's lived experience;</p> <p>(d) Cultural needs, values, and beliefs are considered;</p> <p>(e) Cultural assessments are completed by culturally</p>	PA Moderate	<p>Care plans addressed residents' general needs; however, they did not always describe fully the required support the resident needed to address their complete needs or identify the early warning signs of potential or pre-existing problems. This was regarding management strategies around a potential for pressure injuries, management of a resident's challenging behaviours, the early warning signs for a resident with congestive heart failure, seizures, cellulitis, on anticoagulant therapy, and the identification that the resident was on restraint and the strategies required to manage the risk. There were no assessments</p>	<p>Care plans did not consistently describe the support required to address residents' needs nor record the risks or early warning signs that may adversely affect a resident's wellbeing.</p>	<p>Provide evidence that care plans describe the support required to address residents' needs and record the risks or early warning signs that may adversely affect a resident's wellbeing.</p> <p>90 days</p>

<p>competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia;</p> <p>(f) Strengths, goals, and aspirations are described and align with people’s values and beliefs. The support required to achieve these is clearly documented and communicated;</p> <p>(g) Early warning signs and risks that may adversely affect a person’s wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention;</p> <p>(h) People’s care or support plan identifies wider service integration as required.</p>		<p>sighted for residents identified as using restraint (refer criterion 6.2.1). Two of three residents’ cultural needs were not documented in the care plan. A resident who identified as Pasifika and a resident who identified as Māori had no reference to cultural needs in their care plan. Two deteriorating residents had no update to the care plan to reflect the change in need.</p>		
<p>Criterion 3.2.4</p> <p>In implementing care or support plans, service providers shall demonstrate:</p> <p>(a) Active involvement with the person receiving services and whānau;</p> <p>(b) That the provision of service is consistent with, and contributes to, meeting the person’s assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports</p>	<p>PA Moderate</p>	<p>Care plans reviewed demonstrated active involvement with the resident and their whānau. The documentation in the care plan (identified in criterion 3.2.3) was not always reflective of need and the required care was not always provided. Residents identified as having a pressure injury risk did not have the actions required to minimise that risk addressed. This has resulted in a high number (seven) of facility-acquired pressure injuries. The strategies to minimise the use of</p>	<p>The provision of services was not always consistent with meeting the residents’ assessed needs.</p>	<p>Provide evidence the provision of services is consistent with meeting the residents’ assessed needs.</p> <p>90 days</p>

<p>whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective;</p> <p>(c) That the person receives services that remove stigma and promote acceptance and inclusion;</p> <p>(d) That needs and risk assessments are an ongoing process and that any changes are documented.</p>		<p>restraint with a focus to eliminate restraint are not evidenced to be being used. There were 14 restraints in use at New Vista. The risks associated with restraints were not being addressed daily. The requested monitoring was not evidenced to occur (refer criterion 6.2.2). Residents with wounds were not having these attended to as per the wound care plans. Behaviours that challenge were not monitored as to the effectiveness of any strategies that were effective in minimising them. The risks associated with a number of co-morbidities or medical conditions were not monitored to enable early detection or deterioration.</p>		
<p>Criterion 3.2.5</p> <p>Planned review of a person's care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;</p> <p>(b) Include the use of a range of outcome measurements;</p> <p>(c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations;</p> <p>(d) Identify changes to the person's care or support plan,</p>	<p>PA Moderate</p>	<p>In files reviewed, there was evidence of a six-monthly evaluation of the care plan; however, this did not include evidence of review to identify changes required to the support required to achieve the agreed outcomes, for example, pressure injury management, wound management, strategies to manage the residents' behaviours that challenge, restraint management (refer criterion 6.2.7), changing residents' conditions.</p>	<p>There was no planned review of care plans that recorded the degree of achievement and identified changes required to meet residents' needs.</p>	<p>Provide evidence there is planned review of care plans that records the degree of achievement and identifies changes required to meet residents' needs.</p> <p>90 days</p>



<p>which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented;</p> <p>(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>Criterion 4.2.3</p> <p>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.</p>	PA Low	<p>Staff have not been trained in fire and emergency procedures in 2022 or 2023; however, civil defence training did take place in 2023 and staff were able to describe what to do in a fire or civil defence emergency.</p>	<p>Staff have not been trained in fire and emergency procedures in 2022 or 2023.</p>	<p>Provide evidence that staff have been trained in fire and emergency procedures.</p> <p>180 days</p>
<p>Criterion 5.1.3</p> <p>There shall be a documented pathway for IP and AMS issues to be reported to the governance body at defined intervals, which includes escalation of significant incidents.</p>	PA Low	<p>There was no evidence available to support that IP and AMS was discussed at governance level, except for the reporting of significant events, for example, COVID-19 or any other transmissible infection.</p>	<p>There was no documented pathway for IP and AMS issues to be reported to the governance body at defined intervals.</p>	<p>Provide evidence of a documented pathway for IP and AMS issues to be reported to the governance body, specifying the intervals at which this will occur.</p> <p>180 days</p>
<p>Criterion 5.2.1</p> <p>There is an IP role, or IP personnel, as is appropriate for</p>	PA Moderate	<p>There is an IP role; however, interviews, observation and documentation verified that the</p>	<p>There is an IP role; however, the person appointed was not familiar with, and had no</p>	<p>Provide evidence there is an experienced ICO in the IP role and that there is a job</p>

<p>the size and the setting of the service provider, who shall:</p> <p>(a) Be responsible for 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>person appointed to the role verbalised they had no knowledge, continuing education, or expertise in the role. The ICO does not have a job description in place to assist with understanding the parameters of the role.</p>	<p>experience in, IP or AMS and does not have a job description in place to guide practice.</p>	<p>description in place to guide practice.</p> <p>90 days</p>
<p>Criterion 5.2.12</p> <p>Service providers shall provide educational resources that are available in te reo Māori and are accessible and understandable for Māori accessing services.</p>	<p>PA Low</p>	<p>Staff who identify as Māori can ensure Māori accessing services have access to information; however, there were no educational resources available in te reo Māori.</p>	<p>There were no educational resources available in te reo Māori at New Vista.</p>	<p>Provide evidence that there are educational resources available in te reo Māori.</p> <p>180 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</p>	<p>PA Low</p>	<p>There is a clearly defined IP programme; however, there was no evidence that the IP programme was linked to the quality improvement programme. Meeting minutes for</p>	<p>There was a clearly defined IP programme; however, it was not linked to the quality improvement programme or reviewed annually.</p>	<p>Provide evidence there is a clearly defined IP programme that is linked to the quality improvement programme and reviewed annually.</p>

<p>expertise;  (b) Approved by the governance body;  (c) Linked to the quality improvement programme; and  (d) Reviewed and reported on annually.</p>		<p>staff, RNs/ENs, quality and governance meetings do not include any information regarding IP and AMS. The programme had not been reviewed annually.</p>		<p>180 days</p>
<p>Criterion 5.2.6  Infection prevention education shall be provided to health care and support workers and people receiving services by a person with expertise in IP. The education shall be:  (a) Included in health care and support worker orientation, with updates at defined intervals;  (b) Relevant to the service being provided.</p>	<p>PA Low</p>	<p>Observations and interviews evidence compliance with IP policies and processes; however, there had been no training in IP and AMS provided to staff at New Vista since 2021.</p>	<p>There has been no IP and AMS training at New Vista since 2021.</p>	<p>Provide evidence of recent IP and AMS training.   180 days</p>
<p>Criterion 5.2.7  A person with IP expertise shall be involved in procurement processes for equipment, devices, and consumables used in the delivery of health care.</p>	<p>PA Low</p>	<p>There was no evidence that advice from the ICO had been sought when making decisions around procurement relevant to care delivery, facility changes, and policies. The ICO currently in place was unaware of their role in this respect; however, no profound changes had recently been made to the service.</p>	<p>Advice from the ICO had not been sought when making decisions around procurement relevant to care delivery, facility changes, and policies.</p>	<p>Provide evidence of the processes in place to make sure advice from the ICO is sought when making decisions around procurement relevant to care delivery, facility changes, and policies.   180 days</p>
<p>Criterion 5.3.3</p>	<p>PA Low</p>	<p>Interviews with the CNM, a RN, and</p>	<p>New Vista has implemented</p>	<p>Provide evidence New Vista</p>

<p>Service providers, shall evaluate the effectiveness of their AMS programme by:  (a) Monitoring the quality and quantity of antimicrobial prescribing, dispensing, and administration and occurrence of adverse effects;  (b) Identifying areas for improvement and evaluating the progress of AMS activities.</p>		<p>the appointed ICO identified there was an AMS programme in place, provided by an external advisory company; however, New Vista has not undertaken any work to reduce the use of antimicrobials at this time.</p>	<p>the AMS programme but has not evaluated the effectiveness of the AMS programme or identified areas for improvement, nor have they looked at strategies to reduce the use of antimicrobials.</p>	<p>has implemented and evaluated the effectiveness of the AMS programme and identified areas for improvement, including in the use of antimicrobials.</p> <p>180 days</p>
<p>Criterion 5.4.4  Results of surveillance and recommendations to improve performance where necessary shall be identified, documented, and reported back to the governance body and shared with relevant people in a timely manner.</p>	<p>PA  Moderate</p>	<p>Interviews, observation, and documentation verified the results of surveillance and recommendations to improve performance, were not reported to staff, management, or the governing body.</p>	<p>The results of surveillance and recommendations to improve were not reported back to staff, management, or the governing body.</p>	<p>Provide evidence the results of surveillance and recommendations to improve are reported back to staff, management, and the governing body.</p> <p>90 days</p>
<p>Criterion 5.5.5  Service providers shall ensure that the IP role has – or IP personnel have – oversight of the facility testing and monitoring programme for the built environment.</p>	<p>PA Low</p>	<p>No audits have been completed at New Vista in relation to IP. The ICO has no oversight of the facility testing and monitoring programme for the built environment, neither does the ICO have the knowledge or experience to manage this process.</p>	<p>The ICO has no oversight of the facility testing and monitoring programme for the built environment and does not have the knowledge or experience to manage this process.</p>	<p>Provide evidence that the ICO has oversight of the facility testing and monitoring programme for the built environment, and that education is provided to them to ensure they understand their responsibilities.</p> <p>180 days</p>
<p>Criterion 6.1.1  Governance bodies shall</p>	<p>PA  Moderate</p>	<p>The FM and directors of New Vista advised that they are committed to</p>	<p>The governance body has not demonstrated a commitment</p>	<p>Provide evidence of the governance body's</p>

demonstrate commitment toward eliminating restraint.		reducing restraint use in the facility. Policies in place outline restraint minimisation/elimination as the strategy for the service. However, restraint use has increased since the last audit from 10 to 14 residents using a restraint. In the absence of assessment or evaluation of restraint being carried out at New Vista, there is little evidence that alternative options to restraint have been considered.	toward eliminating restraint.	commitment toward eliminating restraint.  90 days
Criterion 6.1.3 There shall be an executive leader who is responsible for ensuring the commitment to restraint minimisation and elimination is implemented and maintained.	PA Moderate	The FM and CNM are not involved in the restraint process at New Vista. The RC is newly appointed and does not have the knowledge or training to oversee the service's commitment to ensuring restraint minimisation and elimination is implemented and maintained. There is no job description in place for the role.	There is no executive leader who is responsible for ensuring the commitment to restraint minimisation and elimination is implemented and maintained. There is no job description in place for the RC to guide their practice.	Provide evidence that the service has an executive leader who is responsible for ensuring the commitment to restraint minimisation and elimination is implemented and maintained, that the person has the knowledge and skills to manage the role, and that they have a job description for the role in place to guide practice.  90 days
Criterion 6.1.4 Executive leaders shall report restraint used at defined intervals and aggregated restraint data, including the type and frequency of restraint, to governance bodies. Data analysis shall support the	PA Low	Restraint is not reported at any level of the service, including to governance. This was confirmed by observation, review of documentation, and at interview with staff and a governance representative.	There are no processes in place to allow restraint to be reported to governance or to staff. Restraint is not reported at any level of the service.	Provide evidence of the processes in place to allow restraint to be reported to governance and to staff and that restraint is being reported at all levels of the service.

implementation of an agreed strategy to ensure the health and safety of people and health care and support workers.				180 days
<p>Criterion 6.1.5</p> <p>Service providers shall implement policies and procedures underpinned by best practice that shall include:</p> <p>(a) The process of holistic assessment of the person's care or support plan. The policy or procedure shall inform the delivery of services to avoid the use of restraint;</p> <p>(b) The process of approval and review of de-escalation methods, the types of restraint used, and the duration of restraint used by the service provider;</p> <p>(c) Restraint elimination and use of alternative interventions shall be incorporated into relevant policies, including those on procurement processes, clinical trials, and use of equipment.</p>	PA Moderate	<p>Policies and procedures are in place, and these are underpinned by best practice, but these are not being implemented by the service.</p> <p>Restraints in use are consented but there is very little narrative in restraint documentation or care plans of resident's using restraint in respect of strategies or alternative interventions that have been used to prevent the use of restraint prior to it being applied (narrative is on the consent forms only).</p>	<p>Restraint policies and procedures are not being fully implemented by the service.</p>	<p>Provide evidence that restraint policies and procedures are being fully implemented by the service.</p> <p>90 days</p>
<p>Criterion 6.1.6</p> <p>Health care and support workers shall be trained in least restrictive practice, safe practice, the use of restraint, alternative cultural-specific</p>	PA Moderate	<p>Clinical staff have not been trained in least restrictive practice, safe practice, the use of restraint, alternative cultural-specific interventions, and de-escalation techniques in 2022 or 2023. This was</p>	<p>Clinical staff have not been trained in least restrictive practice, safe practice, the use of restraint, alternative cultural-specific interventions, and de-escalation techniques in 2022</p>	<p>Provide evidence that clinical staff have been trained in least restrictive practice, safe practice, the use of restraint, alternative cultural-specific interventions, and de-</p>

interventions, and de-escalation techniques within a culture of continuous learning.		evidenced through documentation review and interviews with staff.	or 2023.	escalation techniques.  90 days
<p>Criterion 6.2.1</p> <p>The decision to approve restraint for a person receiving services shall be made:</p> <p>(a) As a last resort, after all other interventions or de-escalation strategies have been tried or implemented;</p> <p>(b) After adequate time has been given for cultural assessment;</p> <p>(c) Following assessment, planning, and preparation, which includes available resources able to be put in place;</p> <p>(d) By the most appropriate health professional;</p> <p>(e) When the environment is appropriate and safe.</p>	PA High	<p>Fourteen (14) of 14 restraint records were reviewed. Minimal information was available (on the consent form only) to show that restraint had been utilised as a last resort, after all other interventions or de-escalation strategies had been tried or implemented. In one instance, a vest harness was indicated as an appropriate restraint when the resident had risen from a chair and may have been at risk of falling (but did not fall), other interventions (e.g., toileting, offer of a drink or walk etc.) were not considered before the restraint was applied. Cultural assessment had also not been undertaken. An assessment form was not completed for any of the residents on restraint, and the planning and preparation required before restraint was put into place was not evident.</p>	<p>The decision to approve restraint for a person receiving services has not been made as a last resort, after all other interventions or de-escalation strategies have been tried or implemented, there has been no cultural assessments, and there is no information available on any of the resident's files to show that restraint was applied after appropriate assessment, planning, and preparation.</p>	<p>Provide evidence that a process has been put into place to ensure restraint is applied only as a last resort and after all other interventions or de-escalation strategies have been tried or implemented. Provide evidence that cultural assessments have been completed and there is information available on the residents' files to show that restraint was applied after appropriate assessment, planning, and preparation.</p> <p>30 days</p>
<p>Criterion 6.2.2</p> <p>The frequency and extent of monitoring of people during restraint shall be determined by a registered health professional and implemented according to this determination.</p>	PA High	<p>The frequency of monitoring was outlined on the consent forms of all residents using restraint by the RC. The rationale for the monitoring was not specified or individualised (all were two-hourly). Monitoring of restraint at two-hourly intervals was not consistently evident on any of the</p>	<p>The frequency and extent of monitoring of people during restraint was determined by a registered health professional, but monitoring was not implemented according to this determination.</p>	<p>Provide evidence that restraint is monitored according to the assessed determination of a registered health professional.</p> <p>30 days</p>

		restraint monitoring forms sighted but there was some monitoring in place. Comments included information such as 'bed rails up or bed rails down'. In most cases there was documentation to show that restraints were checked only once overnight (one documentation for one shift).		
<p>Criterion 6.2.3</p> <p>Monitoring restraint shall include people's cultural, physical, psychological, and psychosocial needs, and shall address wairuatanga.</p>	<p>PA Moderate</p>	<p>Monitoring of restraint did not address people's cultural, physical, psychological, and psychosocial needs, or wairuatanga in any of the records sighted. Minimal information was available on monitoring forms as specified in criterion 6.2.2.</p>	<p>Monitoring of restraint did not address people's cultural, physical, psychological, and psychosocial needs, or wairuatanga in any of the records sighted.</p>	<p>Provide evidence that monitoring of restraint addresses people's cultural, physical, psychological, psychosocial needs, and wairuatanga.</p> <p>60 days</p>
<p>Criterion 6.2.4</p> <p>Each episode of restraint shall be documented on a restraint register and in people's records in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome of the restraint, and shall include:</p> <p>(a) The type of restraint used;</p> <p>(b) Details of the reasons for initiating the restraint;</p> <p>(c) The decision-making process, including details of de-escalation techniques and alternative interventions that were attempted or considered</p>	<p>PA High</p>	<p>Restraint was documented on a consent form with a brief note in care plans for all 14 of the records for residents using a restraint. There was minimal information in residents' records to provide an accurate rationale for use, intervention, duration, and outcome of the restraint. Records did not fully explain the details of the reasons for initiating the restraint, the decision-making process, including details of de-escalation techniques and alternative interventions that were attempted or considered prior to the use of restraint, or details of any advocacy and support offered, provided, or facilitated. In addition to</p>	<p>Restraint was not documented in residents' records in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome of the restraint in use.</p>	<p>Provide evidence that restraint has been documented in residents' records in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome of the restraint in use.</p> <p>30 days</p>



<p>prior to the use of restraint;  (d) If required, details of any advocacy and support offered, provided, or facilitated; NOTE – An advocate may be: whānau, friend, Māori services, Pacific services, interpreter, personal or family advisor, or independent advocate.  (e) The outcome of the restraint;  (f) Any impact, injury, and trauma on the person as a result of the use of restraint;  (g) Observations and monitoring of the person during the restraint;  (h) Comments resulting from the evaluation of the restraint;  (i) If relevant to the service: a record of the person-centred debrief, including a debrief by someone with lived experience (if appropriate and agreed to by the person). This shall document any support offered after the restraint, particularly where trauma has occurred (for example, psychological or cultural trauma).</p>		<p>this, records did not document the outcome of the restraint, any impact, injury, and trauma on the person as a result of the use of restraint (or that there were none), or any comments resulting from the evaluation of the restraint.</p>		
<p>Criterion 6.2.7  Each episode of restraint shall be evaluated, and service providers shall consider:  (a) Time intervals between the</p>	<p>PA High</p>	<p>None of the records of residents using restraint (14 from 14) evidenced any evaluation of the use of the restraint. Neither the FM, CNM or RC could produce any records to</p>	<p>None of the records of residents using restraint evidenced any evaluation of the use of the restraint.</p>	<p>Provide evidence that residents using restraint have had a documented evaluation of the use of the restraint.</p>

<p>debrief process and evaluation processes shall be determined by the nature and risk of the restraint being used;</p> <p>(b) The type of restraint used;</p> <p>(c) Whether the person's care or support plan, and advance directives or preferences, where in place, were followed;</p> <p>(d) The impact the restraint had on the person. This shall inform changes to the person's care or support plan, resulting from the person-centred and whānaucentred approach/reflections debrief;</p> <p>(e) The impact the restraint had on others (for example, health care and support workers, whānau, and other people);</p> <p>(f) The duration of the restraint episode and whether this was the least amount of time required;</p> <p>(g) Evidence that other de-escalation options were explored;</p> <p>(h) Whether appropriate advocacy or support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the person;</p> <p>(j) Future options to avoid the use of restraint;</p> <p>(k) Suggested changes or additions to de-escalation education for health care and</p>		<p>show that restraint had been evaluated.</p>		<p>30 days</p>
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<p>support workers;  (l) The outcomes of the person-centred debrief;  (m) Review or modification required to the person's care or support plan in collaboration with the person and whānau;  (n) A review of health care and support workers' requirements (for example, whether there was adequate senior staffing, whether there were patterns in staffing that indicated a specific health care and support workers issue, and whether health care and support workers were culturally competent).</p>				
<p>Criterion 6.3.1  Service providers shall conduct comprehensive reviews at least six-monthly of all restraint practices used by the service, including:  (a) That a human rights-based approach underpins the review process;  (b) The extent of restraint, the types of restraint being used, and any trends;  (c) Mitigating and managing the risk to people and health care and support workers;  (d) Progress towards eliminating restraint and development of alternatives to</p>	<p>PA High</p>	<p>There were no comprehensive six-monthly reviews of restraint practices used by the service and no evidence that the approved restraint was necessary; safe; of an appropriate duration; and in accordance with the person's and health care and support workers' feedback and current evidenced-based best practice. There was minimal evidence to alternative interventions applied on consent forms of all residents using restraint, but these were insufficient to ascribe risk to the resident. Restraint use had increased since the last audit from 10 to 14. There was no risk management related to the use of restraint in the consent</p>	<p>There was no evidence available to support that a comprehensive six-monthly review of restraint use had been conducted at New Vista.</p>	<p>Provide evidence that that a comprehensive six-monthly review of restraint use has been conducted at New Vista.</p> <p>90 days</p>

<p>using restraint;</p> <p>(e) Adverse outcomes;</p> <p>(f) Compliance with policies and procedures, and whether changes are required;</p> <p>(g) Whether the approved restraint is necessary; safe; of an appropriate duration; and in accordance with the person's and health care and support workers' feedback and current evidenced-based best practice;</p> <p>(h) If the person's care or support plans identified alternative techniques to restraint;</p> <p>(i) The person and whānau, perspectives are documented as part of the comprehensive review;</p> <p>(j) Consideration of the role of whānau at the onset and evaluation of restraint;</p> <p>(k) Data collection and analysis (including identifying changes to care or support plans and documenting and analysing learnings from each event);</p> <p>(l) Service provider initiatives and approaches support a restraint-free environment;</p> <p>(m) The outcome of the review is reported to the governance body.</p>		<p>forms or in the residents' care plans for all 14 residents currently using a restraint. There was no evidence to support that the service had considered processes towards eliminating restraint and development of alternatives to using restraint. There was no monitoring of restraint compliance across the process of assessment, monitoring, or evaluation of restraint in the service.</p>		
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.