# Rivercrest Cromwell Limited - Golden View Care

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

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

The specifics of this audit included:

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| **Legal entity:** | Rivercrest Cromwell Limited |
| **Premises audited:** | Golden View Care |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| **Dates of audit:** | Start date: 14 February 2024 End date: 15 February 2024 |

**Proposed changes to current services (if any):** The service was verified as suitable to provide 19 rest home level services in the attached serviced apartments. The service intends to use the beds for residents awaiting transfer to a long-term rest home care bed.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 59

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou 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 haumaru │ 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 |
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| | 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 |
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| | 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 |
| | 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

Golden View Care is a purpose-built facility located in Cromwell. The service is certified to provide rest home, hospital level care (medical and geriatric) and dementia level care for up to 60 residents. There were 59 residents on the days of the audit. The facility manager (registered nurse) oversees the service and is supported by a clinical manager and experienced general manager.

This surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Services Standard and the services contract with Health New Zealand Te Whatu Ora - Southern. The audit process included a review of quality systems, the review of resident and staff files, observations, and interviews with residents, family/whānau, staff, management, and a nurse practitioner.

The service is governed by a Board of Directors who have experience in owning aged care facilities and villages. Golden View has set a number of quality goals which link to the organisation's business plan.

The service has addressed the three previous partial attainments relating to sharing of quality data, care plan evaluations and medication management.

This surveillance audit identified shortfalls related to education, staff appraisals, timeframes and infection reviews.

## Ō tātou motika | Our rights

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| 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. | | Subsections applicable to this service fully attained. |

The service provides an environment that supports residents' rights, and culturally safe care. Details relating to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers Rights (the Code) is included in the information packs given to new or potential residents and family/whānau. A Pacific health and wellbeing action plan is in place.

Residents and family/whānau interviewed confirmed that they are treated with dignity and respect. There was no evidence of abuse, neglect, or discrimination. There is an established system for the management of complaints that meets guidelines established by the Health and Disability Commissioner.

## Hunga mahi me te hanganga | Workforce and structure

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| Includes five 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 low risk. |

The 2023/24 business plan includes specific and measurable goals that are regularly reviewed. The service has implemented quality and risk management systems that include quality improvement initiatives. Internal audits and the collation of clinical indicator data were documented as taking place, with corrective actions as indicated. Hazards are identified with appropriate interventions implemented.

A recruitment and orientation procedure are established. Caregivers are buddied with more experienced staff during their orientation. There is a staffing and rostering policy.

## Ngā huarahi ki te oranga | Pathways to wellbeing

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| Includes eight 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 low risk. |

The registered nurses are responsible for the assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs. Interventions were appropriate and evaluated in the care plans reviewed.

The organisation uses an electronic medicine management system for e-prescribing, and administration of medications. The nurse practitioner is responsible for all medication reviews. Staff involved in medication administration are assessed as competent to do so.

The food service caters for residents' specific dietary likes and dislikes.

Residents are referred or transferred to other health services as required.

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

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| Includes two 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. | | Subsections applicable to this service fully attained. |

There is a current building warrant of fitness. There is a planned and reactive maintenance programme in place.

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

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| Includes five 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 low risk. |

An infection control programme is documented for the service. Staff have attended education around infection control.

Surveillance of health care-associated infections is undertaken, and results are shared with all staff. Follow-up action is taken as and when required. There have been two outbreaks since the previous certification audit.

## Here taratahi | Restraint and seclusion

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| Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained. | | Subsections applicable to this service fully attained. |

The service is committed to maintaining a restraint-free service. This is supported by the governing body and policies and procedures. Staff interviewed demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques and alternative interventions to prevent the use of restraint.

## 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) |
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| **Subsection** | 0 | 13 | 0 | 5 | 0 | 0 | 0 |
| **Criteria** | 0 | 45 | 0 | 5 | 0 | 0 | 0 |

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

# Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

For more information on the different types of audits and what they cover please click here.

| Subsection with desired outcome | Attainment Rating | Audit Evidence |
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| Subsection 1.1: Pae ora healthy futures<br>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.<br>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. | FA | A Māori Health Plan and a cultural safe policy are documented for the service. The Māori health plan is guided by the requirements of Ngā Paerewa Health and disability services standard NZS 8134:2021. The policy acknowledges Te Tiriti O Waitangi as a founding document for New Zealand. There is a documented commitment to recognising and celebrating tāngata whenua in a meaningful way through partnerships, educational programmes, and employment opportunities. Residents are involved in providing input into their care planning, their activities, and their dietary needs. Staff have completed training around cultural safety and Te Tiriti o Waitangi. |
| Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa<br>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.<br>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.<br>As service providers: We provide comprehensive and equitable health and disability services underpinned by | FA | Golden View Care has a policy based on the Pacific Health and Wellbeing Plan (Ola Manuia) 2020-2025 that encompasses the needs of Pasifika and addresses the Ngā Paerewa Health and Disability Services Standard. The aim is to uphold the principles of Pacific people by acknowledging respectful relationships and embracing cultural and spiritual beliefs and providing high quality healthcare. The cultural training provided included Pasifika cultures. There were staff employed at the facility who assist in the implementation of the Pacific health plan. |

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| Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes. | | |
| Subsection 1.3: My rights during service delivery<br><br>The People: My rights have meaningful effect through the actions and behaviours of others.<br>Te Tiriti:Service providers recognise Māori mana motuhake (self-determination).<br>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements. | FA | Five residents interviewed (four hospital and one rest home) and three family/whānau (one hospital and two dementia) reported that all staff respected their rights, and that they were supported to know and understand their rights. Care plans reviewed were resident centred and evidenced input into their care and choice/independence. Staff have completed training on the Code of Rights. The Code of Rights is displayed in English and te reo Māori. |
| Subsection 1.5: I am protected from abuse<br><br>The People: I feel safe and protected from abuse.<br>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.<br>As service providers: We ensure the people using our services are safe and protected from abuse. | FA | An abuse and neglect policy is being implemented. Golden View Care policies prevent any form of discrimination, coercion, harassment, or any other exploitation. A comprehensive code of conduct is discussed and signed by staff during their induction to the service. The code of conduct addresses harassment, racism, and bullying. Staff sign to acknowledge that they accept the code of conduct as part of the employment process.<br><br>Staff complete education on orientation; however, annual training on how to identify abuse and neglect has not been provided (Link 2.3.2). Staff are educated on how to value the older person, showing them respect and dignity. All residents and families/whānau interviewed confirmed that the staff are very caring, supportive, and respectful. The service implements a process to manage residents' comfort funds, such as sundry expenses.<br><br>Professional boundaries are defined in job descriptions. Interviews with registered nurses and caregivers confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation.<br><br>Interviews with 17 staff (eight caregivers, four RN's, one enrolled nurse, one clinical support, two cooks, and one maintenance person), three managers (one clinical manager, one facility manager and one general manager), residents and family/whanau and documentation reviewed, confirmed that the staff are very caring, supportive, and respectful. |

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| Subsection 1.7: I am informed and able to make choices<br><br>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.<br>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,<br>keep well, and live well.<br>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. | FA | There are policies documented around informed consent. Informed consent processes were discussed with residents and family/whānau on admission. Five electronic resident files were reviewed, and all included written general consents for personal and medical including photographs, release of medical information, medication management and medical cares. Specific consent forms had been signed by residents or their activated enduring power of attorney (EPOA) for procedures, such as vaccines and other clinical procedures. |
| Subsection 1.8: I have the right to complain<br><br>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.<br>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.<br>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. | FA | The complaints procedure is equitable and is provided to residents and family/whanau on entry to the service. The facility manager maintains a record of all complaints, both verbal and written, via electronic complaints register. There have been no complaints since the previous audit in June 2022. The complaint documentation including acknowledgement, investigation, follow-up letters and resolution demonstrate that complaints are managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). Staff interviewed confirmed they are informed of complaints (and any subsequent corrective actions) in staff meetings.<br><br>Discussions with residents and family/whānau confirmed they were provided with information on complaints and complaints forms are available at the entrance to the facility. Residents have a variety of avenues they can choose from to make a complaint or express a concern, including the resident meetings which are held monthly. Communication is maintained with individual residents, with updates during activities, mealtimes and during one-on-one reviews. Residents and family/whanau making a complaint can involve an independent support person in the process if they choose. Information about the support resources for Māori are available to |

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| | | staff to assist Māori in the complaints process. The facility manager and clinical staff acknowledged the understanding that for many Māori, there is a preference for face-to-face communication and confirmed their commitment to do this wherever possible. On interview, residents and family/whānau stated they felt comfortable to raise issues of concern with management at any time. |
| Subsection 2.1: Governance<br><br>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.<br>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.<br>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. | FA | Golden View Care is located in Cromwell, provides rest home, hospital, and dementia levels of care for up to 60 residents. This audit also verified Golden View Care is suitable to provide rest home level care for residents in 19 rooms in the attached two storey occupation right agreement apartments (ORA). The service states that the rooms will be for the existing residents who are awaiting a bed in the care facility. This option has not been required to date. The attached care centre provides care for up to 48 dual purpose hospital and rest homes level care and 12 dementia level care residents.<br><br>On the day of the audit, there were 59 residents (17 rest home, 30 hospital and 12 dementia level of care residents). There was one hospital-level residents on an individual exceptional circumstances contract; and one hospital-level resident on respite. The remaining residents were on the age-related residential care contract (ARRC).<br><br>Golden View Care is owned by Rivercrest Cromwell Ltd. The directors also own another facility in Cromwell. There are five directors all of whom are shareholders and one general manager. The board meets monthly. There is a documented annual business management and strategic plan, which informs the quality improvement plan and includes the organisation's foundation, purpose, vision, mission, and values. Key objectives are identified and regularly reviewed by the board at their monthly meetings, as evidenced in the board meeting minutes. The directors of the Board, work with the management teams at the two aged care facilities and understand their obligations and responsibilities under the relevant standards and legislation.<br><br>A clinical governance group has been implemented across the two facilities to provide collaborative accountability for continuous quality improvement activities, including (but not limited to) improvement of services and delivery |

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| | | of a high standard of delivery of care. The framework for the clinical governance committee is informed by the organisation's strategic plan The clinical governance group meets monthly and includes the general manager of Golden View, the clinical manager (CM) and facility manager (FM) representative of each facility, and a member of the board.<br><br>The general manager (board member), facility manager, and clinical manager were interviewed. The general manager has a background in management and is a board member. The general manager is the manager of the sister facility in Cromwell. The clinical manager is an experienced RN manager in aged care. The management team are supported by a clinical support nurse The management team are supported by the directors.<br><br>The organisation is focused on providing respectful end of life care that caters to physical, cultural, and spiritual needs, as evidenced by compliments from family/whānau. The board and management team are in active discussions to discuss and address barriers related to Māori culture and health. The annual business plan reflects a commitment to collaborate with Māori, aligns with the Ministry of Health strategies, and addresses barriers to equitable service delivery.<br><br>There is weekly communication between the general manager and facility manager and open access to members of the board whenever necessary. The board meets monthly and receives a detailed monthly clinical governance report from both facility managers with an overview of adverse events; health and safety; staffing; infection control; use of restraint; and other aspects of the quality risk management programme. Critical and significant events are reported immediately to the directors. |
| Subsection 2.2: Quality and risk<br><br>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.<br>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.<br>As service providers: We have effective and organisation-wide governance systems in place relating to continuous | FA | Golden View Care has an established quality and risk management programme, developed by management team. The systems include performance monitoring through internal audits and through the collection of clinical indicator data using an electronic system.<br><br>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed and changes or changes to policy are |

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| 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. | | communicated to staff.<br><br>The quality system includes performance monitoring; internal audits; resident satisfaction; staff retention; and the collection, collation, and benchmarking of clinical indicator data. Quality goals for 2023 were reviewed by the directors and management team in January 2023. Quality goals for 2024 are documented and progress towards quality goals is reviewed regularly at quality, clinical governance and staff meetings.<br><br>Internal audits, staff meetings, and collation of data were documented as taking place, with corrective actions documented where indicated to address service improvements, with evidence of progress and sign off when achieved. Quality data and trends in data are posted on quality noticeboards.<br><br>Corrective actions are discussed at staff/quality meetings to ensure any outstanding matters are addressed with sign-off when completed. Meeting minutes and quality data graphs are distributed to staff through the electronic resident management system. Staff are alerted to the information when they log in. Management track read status. On interview, staff acknowledged the information system and were aware of quality data indicator results and corrective actions required. The previous partial attainment # 2.2.1 has been addressed. Monthly staff meetings provide an avenue for discussions in relation to (but not limited to) quality data; health and safety; infection control/pandemic strategies; complaints received (if any); staffing; and education. The organisation is implementing a business intelligence tool to improve benchmarking across the two facilities.<br><br>A health and safety system is in place with annual identified health and safety goals. There is a health and safety officer who has completed formal health and safety training. Manufacturer safety datasheets are up to date. Hazard identification forms and an up-to-date hazard register had been reviewed 14 February 2024 (sighted). A staff noticeboard keeps staff informed on health and safety. Staff and external contractors are orientated to the health and safety programme. In the event of a staff accident or incident, a review process is documented on the electronic accident/incident form.<br><br>Electronic reports on the resident management system are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Opportunities to minimise future risks were identified |

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| | | where possible through a corrective action plan and discussions at quality meetings. Incident and accident data is collated monthly and analysed for trending through the electronic resident management system. Results are discussed at the meetings.<br><br>The recent annual family/whānau satisfaction surveys indicate that family/whānau have reported high levels of satisfaction with the service provided. Results will be shared in the next staff, resident and family/whānau meetings, as confirmed on interview with management.<br><br>Discussions with the FM and CM evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been several section 31 notifications completed for registered nurse shortages across all shifts. There have been three section 31's related to absconding incidents since the previous audit. There have been two outbreaks since the previous audit. Management described outbreak management, notifications and staff debriefs. |
| Subsection 2.3: Service management<br><br>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.<br>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.<br>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services. | PA Low | There is an annual education and training schedule documented that includes mandatory training across 2022 and 2023. Training is provided monthly via an online platform and face to face with a record of completion evidenced on staff files. Toolbox talks are held when required or at handovers; however, not all training has been documented as provided according to the training schedule.<br><br>Competencies are completed by staff, which are linked to the education and training programme. Staff complete competency assessments as part of their orientation and annually (included in the education plan) including fire safety; hand hygiene; falls prevention; restraint; challenging behaviours; cultural safety; infection control; personal protective equipment; manual handling; and health and safety). Additional RN competencies cover medication administration; controlled drug administration; wounds, nebuliser; blood sugar levels and insulin administration; and wound management. A record of completion is maintained on an electronic register.<br><br>The service supports and encourages caregivers to obtain a New Zealand Qualification Authority (NZQA) qualification. Out of a total of 31 caregivers, 12 have completed the level four NZQA qualification. The 12 caregivers |

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| | | regularly employed to work in the dementia unit and nine have completed the dementia standards. There are a further three caregivers within the workforce that are currently enrolled. Two staff have been employed for over 18 months and have not yet completed training.<br><br>External training opportunities for care staff include training through Health New Zealand - Southern and the hospice. Registered nurse specific training includes training through the University of Tasmania (understanding dementia, preventing dementia, understanding brain injuries), pressure injury prevention, wound management and infection control. There are eleven RNs (including the FM, CM and clinical support manager), and two enrolled nurses (Ens). Eight RNs are interRAI trained.<br><br>The staffing policy meets with the safe staffing hours and aligns with the ARRC contract with Health New Zealand -Southern. There is at least one RN on each shift. The RNs from the dual-purpose wing spend two to three hours a day in the dementia unit. Staffing is flexible to meet the acuity and needs of the residents, confirmed during interviews with both managers and staff. All registered nurse staff hold current first aid certificates, ensuring a first aid trained staff member on duty 24/7. There have been section 31 notifications regarding previous RN shortages. This has been resolved with full registered nurse cover. The existing staff levels are sufficient to provide cover for one or two rest home residents in the adjoining apartments. Management advised they are unlikely to have more than this; however, should this occur additional staff would be rostered as required.<br><br>Interviews with residents and families/whānau confirmed staffing overall was satisfactory. |
| Subsection 2.4: Health care and support workers<br><br>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. 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. | PA Low | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Staff files are stored securely. Six staff files reviewed evidenced implementation of the recruitment process, employment contracts, police checking and completed orientation programmes specific to their roles. All staff have signed a house rules/code of conduct document at time of employment commencement.<br><br>There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, and additional roles (eg, restraint |

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| 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. | | coordinator, infection control coordinator) for each position. All staff evidenced signed position descriptions.<br><br>A register of practising certificates is maintained for all health professionals. There is a staff appraisal policy documented; however, not all staff who had been employed for over one year have an annual appraisal completed.<br><br>The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. |
| Subsection 3.2: My pathway to wellbeing<br><br>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.<br>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.<br>As service providers: We work in partnership with people and whānau to support wellbeing. | PA Low | Five resident files were reviewed: three hospital level residents (including one on an exceptional circumstances contract and one on a respite contract), one dementia level resident, and one rest home resident. The registered nurses are responsible for conducting all assessments and for the development of care plans. There was evidence of resident and family/whānau involvement for the interRAI assessments and in the long-term care plans reviewed. Family/ whanau involvement was also documented in progress notes, six-monthly care reviews, and family/whānau contact forms. Family/whānau interviewed stated they are involved in the development and evaluation of the care plan.<br><br>All residents have admission assessment information collected and an interim plan completed at time of admission. All long-term resident files, excluding those on exceptional circumstances and respite contracts, had an initial interRAI assessment completed; however, not all reassessments have been completed within the required timeframes. Additionally, all files had a suite of electronic assessments (including activities, cultural, and dietary assessments) completed to form the basis of the long-term care plan or initial care plan. Cultural assessments included identification of traditional healing practices where applicable.<br><br>Long-term care plans for all long-term residents had been completed within 21 days. The long-term care plan includes aspects of daily living. Care plan interventions were holistic and addressed all needs in sufficient detail to guide staff in the management of the care of the resident, this is an improvement since the previous audit. Evaluations were completed; however, not all were completed six-monthly. Evaluations contained written |

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| | | progress towards care goals. The content of evaluations is an improvement from the previous audits. The nurse practitioner reviews residents at least three-monthly. Short-term care needs are added to long term care plans for acute issues, including (but not limited to) weight loss, infections, and acute wounds.<br><br>All residents had been assessed by the nurse practitioner (NP) within five working days of admission. The NP service visits routinely weekly and provides out of hours cover. The NP (interviewed) commented positively on the communication and quality of care at the facility. Specialist referrals are initiated as needed. Allied health interventions were documented and integrated into care plans. The service contracts with a physiotherapist ten hours a week and a podiatrist visits every six to eight weeks. Specialist services, including mental health, dietitian, speech language therapist, gerontology nurse specialist, wound care, and continence specialist nurse, are available as required through Health New Zealand -Southern or the district nursing service.<br><br>Care staff interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery. Progress notes are written electronically every shift and as necessary by caregivers and at least weekly by the registered nurses. The registered nurses further add to the progress notes if there are any incidents or changes in health status.<br><br>Residents interviewed reported their needs and expectations were being met, and family members confirmed the same regarding their whānau. When a resident's condition alters, the staff alert the registered nurse who then initiates a review with a NP. Family/whānau stated they were notified of all changes to health, including infections, accident/incidents, NP visit, medication changes and any changes to health status, and this was consistently documented on the electronic resident records.<br><br>There were 47 current wounds (surgical wounds, skin tear, abrasions, ulcers, lesions and others). Six wounds reviewed had comprehensive wound assessments, including photographs to show the healing progress. An electronic wound register is maintained, and wound management plans are implemented. There is access to the district nurse and clinical nurse specialist. There was one pressure injury (stage one) at the time of the audit. Caregivers and RNs interviewed stated there are adequate clinical supplies and equipment provided, including wound care supplies and |

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| | | pressure injury prevention resources. Continence products are available and resident files included a continence assessment, with toileting regimes and continence products identified for day use and night use.<br><br>Caregivers and the registered nurses complete monitoring charts, including bowel chart; reposition charts; vital signs; weight; food and fluid chart; blood glucose levels; and behaviour as required. Incident and accident reports reviewed evidenced timely RN follow up, and relatives are notified following adverse events (confirmed in interviews). Opportunities to minimise future risks are identified by the clinical manager or clinical support nurse, who reviews every adverse event before closing, neurological observations have been completed as per the falls management policy and neurological observation policy. |
| Subsection 3.4: My medication<br><br>The people: I receive my medication and blood products in a safe and timely manner.<br>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.<br>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. | FA | There are policies available for safe medicine management that meet legislative requirements. Staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has not been evidenced as being provided (Link 2.3.2).<br><br>Staff were observed to be safely administering medications. The registered nurses and caregivers interviewed could describe their role regarding medication administration. The service uses robotic packaging packs for regular medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. The effectiveness of 'as required' medications is recorded in the electronic medication system and in the progress notes.<br><br>All medications are stored securely in one of the two dedicated medication rooms. Medications reviewed were appropriately stored in the medication trolley and medication rooms. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. Expired medicines were being returned to the pharmacy promptly. All eyedrops have been dated on opening. The previous partial attainment #3.4.3 has been addressed.<br><br>Ten electronic medication charts were reviewed. The medication charts reviewed identified that the NP had reviewed all resident medication charts three-monthly, and each medication chart has photo identification and |

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| | | allergy status identified. The previous partial attainment #3.4.4 has been addressed. There were no resident self-administering their medications. The medication policy describes the procedure for self-medicating residents, and this has been implemented as required. There are no standing orders in use.<br><br>Medication incidents were completed in the event of a drug error and corrective actions were acted upon. A sample of these were reviewed during the audit. |
| Subsection 3.5: Nutrition to support wellbeing<br><br>The people: Service providers meet my nutritional needs and consider my food preferences.<br>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.<br>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing. | FA | Residents' nutritional requirements are assessed on admission to the service in consultation with the residents and family/whānau. The nutritional assessments identify residents' personal food preferences, allergies, intolerances, any special diets, cultural preferences, and modified texture requirements. A daily running sheet ensures residents receive their special diets and food preferences. Copies of individual dietary preferences were available in the kitchen folder. A food control plan is in place and expires in April 2024. |
| Subsection 3.6: Transition, transfer, and discharge<br><br>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.<br>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.<br>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. | FA | A standard transfer notification form is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families/whānau were involved in all discharges and transfers to and from the service and there was sufficient evidence in the residents' records to confirm this. Records sampled evidenced that the transfer and discharge planning included risk mitigation and current residents' needs. The discharge plan sampled confirmed that, where required, a referral to other allied health providers to ensure the safety of the resident was completed. |

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| Subsection 4.1: The facility<br><br>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.<br>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.<br>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. | FA | Appropriate systems are in place to ensure the resident's physical environment and facilities are fit for purpose. There is a proactive and reactive maintenance programme, and buildings, plant, and equipment are maintained to an adequate standard. There is a current building warrant of fitness that expires on 4 August 2024. All electrical equipment is tested and tagged, and bio-medical equipment calibrated. Water temperatures were monitored and recorded. Residents and family/whānau interviewed were happy with all aspects of the environment. Spaces were culturally inclusive and suited the needs of the resident groups.<br><br>The adjoining apartments are located beside the care facility and are suitable for rest home care with call bells and self-contained amenities. The apartments can be accessed from internal doors on both levels. |
| Subsection 5.2: The infection prevention programme and implementation<br><br>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.<br>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.<br>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services. | PA Low | The infection prevention control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, and the training and education of staff. Policies and procedures are provided by an external consultant with input from infection control specialists and reviewed by the management team and governance. Policies are available to staff and linked to the quality system. Infection control is included in the internal audit schedule. Any corrective actions identified have been implemented and signed off as resolved. The infection control programme is reviewed monthly however annual reports are not completed.<br><br>The infection control policy states that Golden View Care is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan. The infection control coordinator has undertaken recent online education both online and is enrolled to attend Health New Zealand-Southern training session in May 2024. All staff have completed infection prevention and control in-services and associated competencies, such as handwashing and the use of personal protective equipment. |
| Subsection 5.4: Surveillance of health care-associated | PA Low | The infection prevention control policy describes surveillance as an integral part of the infection prevention control programme. Monthly infection data is |

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| infection (HAI)<br><br>The people: My health and progress are monitored as part of the surveillance programme.<br>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.<br>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. | | collected for all infections based on signs, symptoms, and the definition of the infection. Infections are entered into the electronic infection register and surveillance of all infections (including organisms) is collated onto a monthly infection summary. Reports include antibiotic use. This data is monitored and analysed for trends. Golden View Village does not yet incorporate ethnicity data into surveillance methods and data captured around infections. Infection control surveillance results are discussed at clinical meeting, quality meetings and staff meetings. Electronic messages are sent to staff as appropriate in relation to infections and outbreaks. Meeting minutes and data are available for staff. Action plans are completed for any infection rates of concern.<br><br>Golden View receives regular notifications and alerts from Health New Zealand – Southern for any community concerns. There have been two outbreaks (respiratory outbreak in October and Covid 19 from December 2023 to January 2024) reported since the previous audit. The infection prevention coordinator described appropriate management and notification of recent outbreaks. |
| Subsection 6.1: A process of restraint<br><br>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.<br>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.<br>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination. | FA | An interview with the restraint coordinator described the organisation's commitment to restraint minimisation. This is supported by the governing body and policies and procedures. On the days of audit there was no restraint in use. The clinical manager is the restraint coordinator.<br><br>Staff attend training in behaviours that challenge and de-escalation techniques. Alternatives to restraint, behaviours that challenge, and residents who are a high falls risk are discussed at quality and staff meetings. Any use of restraint and how it is being monitored and analysed would be reported at these meetings.<br><br>A comprehensive assessment, approval, monitoring, and quality review process is documented for all use of restraint. At all times when restraint is considered, the facility will work in partnership with Māori, to promote and ensure services are mana enhancing, and the cultural advisor will be consulted as required. |

# 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) |
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| Criterion 2.3.2<br>Service providers shall ensure their health care and support workers have the skills, attitudes, qualifications, experience, and attributes for the services being delivered. | PA Low | All care staff are encouraged to complete NZQA standards, and most caregivers have attained level three or four. Twelve caregivers regularly work in the dementia unit and nine have completed their dementia qualifications. An education planner including all mandatory topics is documented; however, has not been fully implemented | i). Two of three staff working in the dementia unit for over 18 months have enrolled in their required NZQA standard but have not completed the qualification.<br>ii). Mandatory training topics have not been evidenced as being provided as required including abuse and neglect, sexuality and intimacy, medication, pain management, advanced directives and informed consent, skin management, safe food handling and health & safety. | i). Ensure staff who are working in the dementia unit have completed required NZQA standards within 18 months.<br>ii). Ensure mandatory training is provided as required by legislation.<br>90 days |
| Criterion 2.4.5 | PA Low | Annual appraisals are scheduled and provide an opportunity for staff to review | Two of six staff files for staff employed over 12 months | Ensure all staff have an appraisal |

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| Health care and support workers shall have the opportunity to discuss and review performance at defined intervals. | | their performance and discuss training needs. Four of six files reviewed identified up to date appraisals as planned. | reviewed did not evidence a current appraisal. | completed annually.<br><br>90 days |
| Criterion 3.2.1<br>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this. | PA Low | Initial assessments and care plans have been developed within the required timeframes for all five files reviewed. Initial interRAI assessments have been completed within the required timeframes for two residents (two resident did not require an interRAI assessment, and one resident had not been in long enough to require an assessment). Three of five resident files identified long-term cares plans had been documented with 21 days of admission (two residents had been at the facility prior to the previous surveillance audit and one resident had not been at facility long enough to require a long-term care plan). Six monthly interRAI reassessments and long-term care plan reviews had been completed for three residents; however, these were not completed within expected time frames (two residents had not been at the facility long enough to require reviews). The service was aware of documentation delays and a corrective action plan had been documented and reviewed at the time of audit with confirmation of good progress. | i). InterRAI re assessments were not completed as scheduled for three of five residents where reviews were required over the previous year.<br>ii). Six-monthly evaluations were not completed within required timeframes for three of five files where reviews were required. | i). Ensure interRAI reassessments are completed six monthly.<br>ii). Ensure care plan evaluations are completed at least six-monthly.<br><br>90 days |
| Criterion 5.2.2<br>Service providers shall have a | PA Low | The annual infection programme is based on policies supplied by an external consultant. Infection reviews are | An annual infection control review has not been evidenced as | Ensure an annual review of the infection control program is |

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| clearly defined and documented IP programme that shall be:<br>(a) Developed by those with IP expertise;<br>(b) Approved by the governance body;<br>(c) Linked to the quality improvement programme; and<br>(d) Reviewed and reported on annually. | | completed monthly; however, an annual review and report are not evidenced as completed. | completed. | completed and reported.<br><br>90 days |
| Criterion 5.4.3<br><br>Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data. | PA Low | Surveillance is based on standardised surveillance definitions. The facility includes comprehensive information on all infections and antibiotic use; however, has not included resident ethnicity. | The service does not currently include ethnicity in infection surveillance. | Ensure ethnicity is included in infection surveillance.<br><br>90 days |

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

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

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

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

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End of the report.