Metlifecare Limited - Metlifecare Papamoa Beach Village Ltd

Introduction

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

The audit has been conducted by 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 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Metlifecare Limited
Premises audited:	Metlifecare Papamoa Beach Village Ltd
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: 1 July 2021 End date: 2 July 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 40

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Metlifecare Papamoa Beach Village Care home (Papamoa Beach Village) provides rest home and hospital level care for up to 24 residents and dementia care for up to 16 residents. The service is operated by a nurse manager and a senior registered nurse with oversight from the village manager and a regional clinical manager.

Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, and a nurse practitioner.

The audit has resulted in three continuous improvements in relation to good practices around quality improvement processes, the admission agreement and restraint elimination. There were no areas identified for corrective action.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Although there are currently no residents who identify as Māori, there is evidence to indicate they would have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

Information about how to make a complaint is readily available. A complaint register is maintained with evidence that complaints are resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

A change pf ownership has seen the release of a new business plan and a restructure of the business is commencing. Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monthly monitoring reports are provided to all levels of the current management structure to the governing body. A suitably qualified person manages the facility with support from a village manager and regional managers.

The quality and risk management system has a strong focus on quality improvement processes. Quality improvement data is collated and analysed, trends are identified and improvements implemented when indicated. Staff are involved and feedback is sought from residents and families. Adverse events and internal audits are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

Human resource processes ensure employment practices are effective, based on current good practice and meet legislative requirements. New staff orientation is planned, documented and reviewed. Ongoing training supports safe service delivery and meet contractual requirements. Annual individual performance reviews are occurring. Staffing levels are safe and ensure appropriate staff skill mixes are rostered according to residents' needs.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.

Any prospective resident is required to have a needs assessment prior to entry. Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse, nurse practitioner and/or general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

This purpose-built facility is modern and clean. A current building warrant of fitness is on public display. Electrical equipment is tested as required and calibration checks on equipment for use with residents are completed annually. Communal and individual spaces are spacious and the temperature comfortable. The maintenance schedule is upheld and any required repairs completed. External areas are accessible, safe and provide shade and seating.

Waste management processes meet infection control requirements. Hazardous substances are managed according to manufacturers' instructions. Personal protective equipment and clothing are available for staff use. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken offsite and cleaning and laundry processes are evaluated for effectiveness.

Staff are trained in emergency procedures and the use of emergency equipment. Emergency supplies are available. Fire evacuation procedures are practised monthly. A review of the call bell system now enables staff to respond to call bells in a timely manner. Appropriate security processes are maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		All standards applicable to this service fully attained with some standards exceeded.

Policies and procedures that support the elimination of any form of restraint are in place. There are no enablers or restraints in use and this is consistent with the organisation's policy and intention. Staff described a sound knowledge and understanding about restraints and enablers and were aware of any use of an enabler is to be voluntary and according to the person's request.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection prevention and control programme aims to prevent and manage infections and is led by an experienced infection control coordinator with support from the nurse manager and the regional clinical manager who has experience in this field. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education being available for the staff.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	3	42	0	0	0	0	0
Criteria	3	90	0	0	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Papamoa Beach Village has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately. Informed consent was part of the resident's admission agreement. Families confirmed this was discussed always on admission and for some, prior to admission. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. All residents residing in the dementia unit had documentation on file confirming enactment of the health and welfare enduring power of attorney. Staff were observed to gain verbal consent, as able, from residents prior to assisting them with any

		aspect of their care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Pamphlets about the health and disability code of rights were visible on the front of reception desk. Brochures related to the Advocacy Service were made available during the audit. Family members and some residents spoken with were aware of the code of rights but not the Advocacy Service. All however felt able to discuss any concerns or thoughts with the nurse manager without the need to make an appointment. Relatives spoken with stated they would know where to seek help outside the facility if they needed to.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment. The facility supports the philosophy of person-centred care, where the resident is in charge of where and when all aspects of activities for daily living occur. The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. A relative spoken with stated she had been able to stay within the facility overnight even though the resident was not receiving palliative care. Relatives stated they were made to feel very welcome and was provided with a bed and private area. A large room, with small kitchen facility was shown as an area that is made available to families of residents receiving palliative care especially or for relatives who need to stay over.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Additional information and copies of forms are available, and were sighted, in the front reception area. The complaint register was reviewed and showed that seven complaints have been received since the facility opened in September 2019. Five of these related to care, one to a misinterpretation of the admission agreement and one for a pair of lost spectacles. Records confirmed that in each instance there was open communication, actions towards agreed resolutions and the complainant was generally satisfied with the response. Improvements had been made where relevant and examples of follow-up staff education were evident.

		Staff interviewed confirmed they had a sound understanding of the complaint process, were aware of the availability of complaint forms and stated they would escalate concerns to the manager or the registered nurse on duty. There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Many residents interviewed were not able to express their understanding of the code; however the family members interviewed stated being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission interview. Pamphlets on the health and disability consumer rights were provided in the admission pack. The Code is displayed in English and te reo Maori in the reception area near the front entrance. A suggestion box is on the front of the reception desk for easy access and is checked regularly by the nurse manager.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room with a private ensuite. Residents are encouraged to maintain their independence. Documentation in the care plans described each person's level of independence according to their abilities and staff were observed assisting residents and reminding them of the next step in a process, as with eating a meal. Care plans included documentation related to the resident's abilities and strategies to maximise independence. Respect and dignity are promoted by allowing the residents to direct the timing of their tasks and care. This was witnessed during the audit with staff accepted the resident's wishes to not have breakfast at a certain time. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori	FA	While there are no residents who identify as Māori currently, staff were able to explain how they would be supported to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan last reviewed 23 April 2021 developed with input from cultural advisers. Guidance on tikanga best

have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		practice is available and is supported by staff who identify as Māori in the facility and by kaumatua from the local Marae.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were captured in the activity assessments and in the know me booklets. This information was included in the care plans to ensure the care provided was holistic, and covered the residents psycho- social, spiritual and cultural needs. Family members confirmed they were consulted on their individual culture, values and beliefs and that they believed the staff respected these. According to the nurse manager, they had two residents who identified as Dutch and some who identified as British with the remainder residents identify as New Zealand/European. One resident regularly leaves the facility to attend his church. An interdenominational Christian fellowship group met regularly within the facility.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents, family members and two visiting health professionals, interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	The service encourages and promotes good practice through evidence based policies, input from allied health professionals, for example physiotherapist, wound care specialist and mental health services for older persons, and education of staff. The nurse practitioner confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. A structured quality improvement template is being used to plan and implement projects and initiatives intended to address shortcomings or corrective actions at a higher level than just addressing the presenting issue. Examples of such projects include one on brain health with an aim to improve understanding about dementia, the assessment and management of acute confusion, a falls prevention

		project which included a focus on increasing the prescription of Vitamin D, development of 24 hour activities plans in the dementia service and one on ensuring conversations about palliative stages of care are undertaken earlier and are more effective for relatives and the residents concerned. With ongoing high falls rates the falls prevention project has been eliminated as part of the continuous improvement for this standard. Similarly, the one on 24 hour activity plan was considered to primarily be meeting the contractual requirements, therefore was also eliminated. However, continuous improvement processes are being used for the implementation of these initiatives.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Relatives stated they were able to access the nurse manager when visiting to discuss any aspect of care. Staff knew how to access interpreter services, although reported this had never been required as all residents able to speak English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Metlifecare was brought out by the EQT Asia Pacific Care Group in November 2020 and although the Metlifecare name has been retained, there is a new board of directors and a new Chief Executive Officer, who commenced in June 2021. A three to five year 'Full Potential Plan' is to be rolled out this year but meantime a 2021 business plan is being implemented. This includes evidence of a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, goals, actions and measures, budget planning and three company-wide goals relating to risk identification and management, quality improvement and resident focused services. Core values of passion, respect, integrity and teamwork remain. There are 11 care homes in the Metlifecare group. Advice of reorganisation of the Metlifecare-owned companies was released in May 2021. This informed that the Papamoa Beach Village, which was an individual company owned by Metlifecare Papamoa Beach Limited, would merge with other similar individual companies into a single entity of Metlifecare Retirement Villages Limited, taking effect from 30 June 2021. This is not expected to have any impact on current residents. Each month the nurse manager provides a monitoring report to the Papamoa Beach Village manager, which is reviewed and passed on to the regional operations manager, the general manager of operations and finally the chief executive officer. The senior registered nurse and the nurse manager

		work alongside the regional clinical manager who reports to the clinical director and has been a member of the Metlifecare executive team since 2016. An executive team meeting is held weekly and the meeting agenda includes relevant components to monitor the organisation's performance. The clinical director has worked at Metlifecare for six years and meets individually with other members of the executive team as required. Due to the senior registered nurse being unavailable during the audit, the nurse manager took on this role and the regional clinical manager assisted as nurse/facility manager. This service is usually managed by the nurse manager who is also a registered nurse and was previously the senior registered nurse for the Papamoa Beach Village. The village manager informed during interview that they recognised management potential and offered the position. A leadership training plan has commenced and the nurse manager is supervised by the village manager and assisted by the regional clinical manager and region al operations manager. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirms knowledge of the sector, regulatory and reporting requirements and seeks assistance when necessary. The service holds contracts with the Bay of Plenty District Health Board to provide rest home, respite, dementia and hospital level aged care services under the Age Related Residential Care Agreement. One wing of the facility is a secure dementia unit known as Toitoi and has 16 beds, all of which were occupied on the day of audit. Two other wings of 12 beds each, namely Dunes and Ocean are all dual purpose beds for rest home or hospital level care. At the time of audit 20 residents were receiving hospital level care and four rest home care. One person receiving rest home care was on a respite contract. A hospital care person was on an individual contract with additional funding under chronic health conditions to have a care companion to provide care and support for four hours in the morning and four hours in the afternoon/evening.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the nurse manager, the senior registered nurse would take in the management role under delegated authorities. The regional clinical manager explained that only one nurse manager in the facilities in the Bay of Plenty may take annual leave at any one time. This enables the regional nurse manager to oversee the facility during the absence of the nurse manager. There are sufficient numbers of registered nurses in the cluster of Metlifecare facilities in the Bay of Plenty to provide additional support if required. Staff reported the current management arrangements and availability of registered nurse advice work well.
Standard 1.2.3: Quality And Risk Management Systems	FA	Papamoa Beach Village has a planned comprehensive quality and risk system with a significant focus on continuous quality improvement that is consistent with expectations of the wider organisation,

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		Metlifecare. This is consistent with the village quality plan 2020 – 2022. Continuous quality improvement is demonstrated in the large number of improvement projects currently in place. A number of these are described in Standard 1.8 of this report. The quality and risk system is implemented under the jurisdiction of the regional clinical manager with support from managers and staff of the care facility. Quality and risk review processes are integrated into monthly registered nurse and in staff meetings, rather than in separate quality team meetings. Information and associated data related to key performance indicators are extracted from the electronic system for a range of clinical indicators, including incident reports, falls, pressure injuries and infection rates. Meeting minutes confirmed that complaints and compliments, updates and reminders, staff education and internal audit outcomes are also discussed. The health and safety team, which meets every two months, provide a report and ensure reviews and updates of this system are up to date. Meeting minutes reviewed confirmed that regular review and analysis of quality indicators are occurring. Internal audits are being completed according to the 2021 schedule and any shortfall is documented and an action plan developed and followed through. Benchmarking of data of quality and clinical indicators is being undertaken with other Metlifecare facilities as well as with five other similar corporate led aged care services. The regional clinical manager and the clinical director described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. An organisational risk register is an electronic document and is regularly reviewed by executive team and the board of directors, and the clinical risk component was sighted during audit. The clinical director is very satisfied that new and changing risks are communicated in a timely manner, and mitigation strategies implemented and monitored for effectiveness. Staff reported their involvement in quality and risk management activities through meeting attendances, reading the meeting minutes if unable to participate, attending training and following through on requests from registered nurses and managers. Corrective actions are developed and implemented to address any shortfalls and these were evident in documentation related to quality activities. Resident and family satisfaction surveys are completed annually; however, these were not distributed in 2020 due to COVID-19. The 2021 survey is being overseen by an independent company that has recently distributed the questions. The results are due mid-July, therefore not available at the time of audit. Regular resident meetings, open communication processes and the nurse manager's open door policy provide alternative platforms to address resident and family member concerns. Issues of concern such as meals, activities and laundry are discussed under updates within staff meetings and solutions found and recorded. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. Regional clinical managers and the clinical governance committee are consulted about applicable policies. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of

		obsolete documents. The regional nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. These occur at both the organisational level and the facility level. Health and safety representatives are familiar with the Health and Safety at Work Act (2015) and as per staff meeting minutes, requirements are being met. The Metlifecare clinical governance committee meets two monthly. This meeting is attended by the clinical director, the four regional clinical managers, a nurse manager representative, a village manager representative and the organisation's nurse educator. A resident living in one of the retirement villages is also a member of committee. Minutes of three meetings demonstrate a coordinated approach to assessing and monitoring key components of service delivery, quality and risk. There are bi-monthly national clinical manager team meetings. These are held alternate months to the clinical governance meeting ensuring regular review of quality and risk issues.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse and near miss events on an accident/incident form within the electronic recording system. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Open disclosure is the responsibility of the nurse manager or the senior registered nurse. Adverse event data is collated, analysed and reported to staff meetings. Staff reported this information is also displayed on staffroom noticeboards and any specific issues may be discussed in toolbox talks. The regional clinical manager and the nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there have been two Section 31 reports made in 2021, one being for aggression and another for a person who briefly left the secure dementia service. Such incidents are reported to the regional clinical manager and to the Metlifecare clinical director. An analysis of such an event is completed and action plans are implemented to prevent further occurrences. A section 31 notification was also made by another regional manager in relation to the change in the ownership of Metlifecare.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes a formal application process, an initial interview, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. These included evidence of use of a recruitment service when the facility first opened.

the requirements of legislation.		Staff orientation includes all necessary components relevant to the person's specific role. The orientation process includes a checklist component and requires the completion of a self-directed learning package followed by an interview with the senior registered nurse and/or the nurse manager. Two days of orientation followed by three days of buddying on the shifts the person is expecting to work on are planned, Staff reported that the orientation process works well and timeframes may be extended if someone is not ready or requests additional time. Staff records reviewed show documentation of completed orientation and an interview with a manager at around 90 days. A training plan 2021 to 2023 was sighted and although specific to for Papamoa Beach Village, it is generic for the three Metlifecare Bay of Plenty facilities and is a skeleton only of what is offered on monthly training days after staff meetings. Mandatory training days are repeated every few months and one of these must be attended by each care staff person each year. All new staff are rostered onto the next mandatory training day available after they commence. Topics cover those as required by the DHB contract, topics of special interest plus any emergent issues such as COVID-19 for example. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Those working in the dementia care area have either completed or are enrolled in the required education, with most having completed it and maintaining currency during mandatory training days. Toolbox talks from registered nurses during staff handover timeslots cover reminders about issues of concern. Attendance is recorded. Registered nurses have access to DHB and on-line clinical training opportunities covering a wide breadth of mandatory, recommended and personal interest topics. Three of the five registered nurses, plus the nurse manager, are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A staffing rationale and rostering policy and procedure states the care home will be staffed in line with recognised, relevant guidelines and evidence-based literature and that staffing will also enable cost effective and efficient quality care. Rostered hours are guided by the recommendations in the NZ Handbook: Indicators for Safe Aged-care and Dementia-care for Consumers SNZ HB 8163:2005, from which an Expert Advisory Panel (EAP) have devised a staffing tool. The regional clinical manager informed that a separate high dependency tool has been compared with the EAP one with similar outcomes and noted that they work with the facility nurse manager to consider the acuity of residents' conditions and layout of the facility when finalising working rosters. A roster framework determines the staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The nurse manager, who is also a registered nurse, is scheduled to be on call. In their absence, the village manger and/or the regional clinical manger take on

		this role. There is also access to GPs on call and to registered nurses in three other facilities in a local Metlifecare cluster. Care staff reported there are sufficient staff rostered on each shift, although noted it becomes more difficult if a new staff person or an agency staff is on duty. There were no concerns raised by residents and family interviewed about staffing levels. Observations and review of four random weeks of rosters confirmed adequate staff cover has been provided, with staff consistently replaced in any unplanned absence, or shifts extended until a short shift person can attend. A casual pool shared with three other facilities is available and agency care staff and nurses are used when necessary. Two shifts a day are for one on-one cares for a person on a specific contract. There is 24 hour/seven days a week (24//7) registered nurse coverage for the hospital and as all registered nurses are required to have a current first aid certificate, there is always at least one person on duty with a current first aid certificate. Staff working in the dementia unit have completed relevant training modules.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with nurse practitioner and/or general practitioner and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Clinical notes were managed within an electronic system. The use of this system was to reduce the amount of paper used in the facility. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	CI	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service and by specialist referral from older persons' mental health services for those going into the secure wing (dementia). Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the most appropriate source, their personal doctor, the local hospital or the NASC team for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic

		detail, assessments and signed admission agreements. Additional costs were documented in the admission agreement and service charges comply with contractual requirements. Improvements to admission agreement and associated documents and communication processes are an area of continuous improvement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the transfer forms generated by the electronic system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed the staff at Papamoa beach village had made regular contact with the service. Family of the resident reported being kept well informed during the transfer of their relative.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge reviewed were within the recommended range. Both medication rooms have a heat pump in place to ensure the temperature is consistent. These are managed by the maintenance system. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP/NP review was consistently recorded on the medicine chart. Standing orders are not used,

		as the GP/NP service have an on call and after-hours service. There are no residents who were self-administering medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors with reporting throughout all levels of the company.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by a qualified chef and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian on 16 March 2021. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Tauranga city on 22 November 2019 with the latest review on 13 May 2021. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. For this an electronic system is used that is specific for kitchen management. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of residents coming into one part of the service and then being reassessed and moving to another part of the service was evidenced during the file review. There is a clause in the access agreement related to when a resident's placement can be

		terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as (pain scale, falls risk, skin integrity, nutritional screening and delirium screen), as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Separate to the files are the 24 hour activity plans, for each resident receiving dementia care, and many others as indicated by the nurse's assessments. These clearly describe relevant interventions to be used and are being reviewed as applicable. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The nurse practitioner interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent with challenging behaviours being particularly well catered for. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was readily available, suited to the levels of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements	FA	The activities programme is provided by two activities coordinators who are both training to become diversional therapists under the apprenticeship programme. Their work is supervised by a tutor for the programme, who although not a trained diversional therapist provides supervision and oversight of their work and their academic programme. The DT Programme trainer has been onsite, overseeing their

are appropriate to their needs, age, culture, and the setting of the service.		work to date. There are two separate activity programmes for the residents. One is specifically geared to residents receiving dementia care. Events are run at different times as residents are encouraged to participate in either if and when appropriate as was witnessed on the day of the audit. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly as part of the formal six monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings. Residents interviewed confirmed they found the programme well-arranged as allowed time for family and resting. Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless, this being in the early afternoon. The formal activity programme runs for seven days of the week. This includes word games, exercise class, trips out and walking group. The care givers are encouraged to be involved in activities especially outside of these hours.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes using the electronic system. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another general practitioner. If the need for other non-urgent services are indicated or requested, the GP/NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to bay of plenty mental health and additions service. The resident and the family/whānau are kept informed of the

referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The management of waste and infectious and hazardous substances is described within health and safety and infection control policy and procedure documentation. A contractor is responsible for the removal of waste, including separated recyclable items. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. One of the maintenance team described how they are currently working with a Metlifecare national health and safety office to ensure all chemicals are listed on a chemical register. There is provision and availability of protective clothing and equipment including plastic aprons, gloves, face shields and masks. Staff were observed using such items when applicable.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness with an expiry date of 11 June 2022 is publicly displayed near the front entrance. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment (10 March 2021) and calibration of bio medical equipment (September 2020) is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that hot water temperatures are within recommended levels, residents are safe and independence is promoted. A six monthly environmental audit was last undertaken 12 April 2021, a maintenance register is reviewed monthly and a repair and maintenance system is recorded electronically. External areas are safely maintained and are appropriate to the resident groups and setting. A safe enclosed landscaped internal courtyard enables residents in the dementia service to move in and out as they choose. Residents interviewed confirmed that they are happy with the environment.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	With each resident's room having an ensuite of a toilet, wet area shower and a hand basin, there are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories according to individual requirements, are available to promote resident independence. An additional toilet for resident use is in the Toitoi (dementia service) wing and some residents from the hospital/rest home area may use a visitors' toilet near the front entrance.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	With each of the bedrooms for residents measuring at around 22 square metres, they are of adequate size. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheelchairs and mobility scooters in corridors, storerooms and resident's rooms. Staff and residents reported the adequacy of bedrooms to move mobility and hoisting equipment around. All rooms have been retrofitted for ceiling hoists, although so far only four have been installed.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are three wings in total, one of which is the dementia service. Each has its own lounge and working kitchen area, although the latter is not used for preparation of the main meals. All dining and lounge areas are spacious and enable easy access for residents and staff, although as one manager suggested the additional space may be contributing to some of the falls. Residents can access areas for privacy, if required, and there is a visitors' chair in each resident's room. Furniture is appropriate to the setting and residents' needs. Communal areas are also used for the activities programme and for residents' individual activities.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundering of personal items, duvets and blankets are undertaken off site in a dedicated laundry at another Metlifecare facility. Although a number of items were awaiting identification, which the manager informed usually finds a home, residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundering of bed-linen and towels is undertaken by a private contractor that is responsible for controlling stock in and out of the facility. Two staff constitute the cleaning team and both have received appropriate training from the contracted cleaning chemical supplier. The supplier ensures safety data sheets are available and these were

		viewed. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Interview with a staff person confirmed their awareness of the products supplied, safety of products from residents and demonstrated knowledge of the cleaning schedule and policy documents. Cleaning and laundry processes are monitored through the internal audit programme and results sighted of the latest audits were satisfactory with minor corrective actions that have since been rectified. The managers informed the complaint process and the annual survey are other monitoring processes; however, no such complaints have been received and survey results are as yet unavailable.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 20 August 2019. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 15 June 2021, when a corrective action was raised due to several identified shortcomings related to staff knowledge and fire action notices. These have since been closed out. The new staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food for up to three days, water in roof tanks and in bottles, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 40 residents plus staff. Emergency lighting is regularly tested. The civil defence supplies are stored appropriately and checked six monthly by the nurse manager. Call bells alert staff to residents requiring assistance. A call bell system installed when the building was built proved to be too sensitive and has since been replaced by another, which although still sensor driven is working more appropriately for this facility. Call system audits are completed on a regular basis and there have been no complaints recorded in relation to call bell slow response timeframes. Appropriate security arrangements are in place with a keypad security gate at the front entrance that is closed at night. Surveillance cameras with appropriate signage are installed. Doors and windows are locked at a predetermined time and a security company checks the premises at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe	FA	Papamoa Beach Village uses heat pumps for warmth and cooling, depending on the season, throughout the building, with each resident's room having its own. These are able to be individually adjusted. Windows throughout the facility provide natural light and are openable with security latches in situ. All of the dual purpose rooms in the Ocean and Dunes wings have a ranch slider onto a small deck area. Six

ventilation, and an environment that is maintained at a safe and comfortable temperature.		of the rooms in the Toitoi wing have patio doors that open onto the internal landscaped courtyard. All indoor areas were warm and well ventilated throughout the audit and residents interviewed confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from nurse manager and regional nurse manager. Included in the manual are contact points for further information and support including the IPC at bay of Plenty DHB, the laboratory and GP/NP. The infection control programme and manual are reviewed annually. The senior registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the nurse manager, and tabled at the quality/risk committee meeting. This committee includes the regional clinical manager, nurse manager, IPC coordinator and representatives from food services, household management, maintenance and care staff. The infection data is also presented at the senior nurses group with incorporates representatives from 11 providers throughout the extended area. All infection data is recorded electronically in a system that provides benchmarking against other facilities. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. Residents and staff are encouraged and supported to receive the influenza vaccinations and the COVID-19 vaccinations. A separate folder has been developed to provide information and surveillance as required for COVID-19.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and experience for the role, and has been in this role for one year. The nurse is undertaking a post graduate certificate in infection prevention and control. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP/NP and public health unit. The nurse is supported in this role by the regional clinical manager who has been involved in IPC for many years. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.

		Large stocks of potentially required personal protective equipment were sighted.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in March 2021 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. There is evidence of pandemic planning and education for the staff as well as personal protective equipment training. Education with residents is generally on a one-to-one basis as appropriate for the resident. It included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover to ensure early intervention occurs, with short term care plans being developed to guide the staff. There has not been an infection outbreak since the facility opened however both the nurse manager and the regional clinical manager were able to clearly explain the process they would follow should one occur.

		Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the regional clinical manager and nurse manager. Data is benchmarked externally within the company group and with other providers via the senior nursing group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	CI	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers, should any of these be required. The nurse manager informed that it is their responsibility to ensure the facility meets the requirements of the restraint minimisation and safe practice standard. Staff undertake training about restraint and enabler use and in the management of behaviours that challenge. A continuous improvement attainment rating has been allocated for this standard as the organisation has not only minimised restraint use but has a strong philosophy in relation to the elimination of both enabler and restraint use. This facility is demonstrating effectiveness with the philosophy as the managers reported that there has been no use of any enablers or restraints since the facility opened in September 2019. Documents sighted confirmed these reports.

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	In response to a complaint related to the assessment and management of residents presenting with acute confusion, a confusion assessment form has been developed and registered nurses have all been trained in its use. This tool is now being used six-monthly with residents demonstrating increasing confusion or behaviours of concern and in the event of any episode of acute confusion. Review of this initiative at Papamoa Beach Village has confirmed its use is enabling more comprehensive information to be shared with the medical team in a concise and easy to follow format, more accurate diagnoses of delirium, earlier interventions of required supervision, implementation of behavioural management strategies and ongoing monitoring. It has also made it easier to provide objective feedback to family members. Feedback processes alerted the organisation that ‘End of Life’ care planning and discussions with families could be improved. A surveillance of deaths over a three month period identified the process was not focused on the actual care planning processes, as other systems are in place to address those, but rather highlighted to registered nurses that residents and/or family were overall unprepared for the outcome. Guidelines around the timing of conversations based on Te Ara Whakapiri were developed and shared goals	There is a culture of quality improvement within this service that is demonstrated by implementation and ongoing reviews of a range of projects and initiatives intended to improve the lives of the residents, prevent incidents/injuries and optimise the outcomes of service delivery. Four particular aspects of good practice that demonstrate the culture of continuous improvement are on use of a confusion assessment form, end of life conversations, brain health

		of care have replaced the ceiling of intervention form for all new admissions since March 2021. Registered nurses have now received training on these conversations, which is enabling families and residents to be more prepared. Since implementation of the process, there have been no residents in palliative stages go to the public hospital and there have been no complaints about actions taken during these stages. Progress notes of deceased patients have been reviewed and conversations of what to expect had been transparent for each of the residents, families and staff. A list of perceived benefits to residents and families has been developed as a result of evaluative discussions to date. Staff at the facility recognised some of the village residents were not welcoming of residents from the dementia service visiting the village café and that families of residents often needed extra education around dementia, trajectory of illness, complications, Enduring Power of Attorney and advance care planning. A brain health initiative saw the establishment of a local brain health champion group, brain health seminars in the village, family education sessions, and an education package for village residents and for care home residents and families/whanau on the Dementia Friendly initiative. Evaluations of each aspect have been collected and many questions and positive responses have been expressed. There has been a ready uptake of the Dementia Friendly programme and the managers informed there has been less overt stigma evident. The elimination of restraint has also been identified as a continuous improvement and is described in the relevant standard below. Good practices and processes used for the initiatives described above, and the outcomes achieved, demonstrate continuous quality improvement.	and elimination of restraints.
Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers,	CI	The admission agreement was reviewed and upgraded for the midlands group of cluster homes that include the Papamoa Beach Village care home. This was in response to a complaint raised in another of the care homes in the cluster in relation to a resident not being seen by a GP, but rather a nurse practitioner (NP). There was confusion and a lack of clarity around the GP/NP visits and the contracted medical service provider cover. The previous admission agreement stated that GP services will be provided and did not include that the NP will also be used. The admission agreement was sent for legal review and was subsequently updated. To address the deficit in communication with residents and family/whanau around the medical services provided, the midlands group of care homes has put systems and processes in place to promote the medical and nurse practitioner services and explain any misconceptions. The changes implemented from	In response to a family complaint in the Metlifecare midlands group of cluster homes, the service has reviewed all applicable documentation in use including the admission agreement to more clearly detail the role of a nurse practitioner, and how this role supports clients with service

their family/whānau of choice where appropriate, local communities, and referral agencies.		August 2020 include: -Liaising with the GP and NP around care home visits, with both attending to each care home regularly. At the Papamoa Beach Village care home, the GP and the NP now visit on alternate weeks. Where possible the resident/family are encouraged to meet with the NP on admission. -The GP and NP profile is provided to residents on admission and were also distributed to existing residents and family. -The admission agreement was amended to reflect the use of the GP and NP. Clear guidelines in the agreement around when a resident chooses another medical service that there is need for that GP to be contracted with the service to ensure resident reviews and medical needs are provided as per legislative requirements. -Surveys were conducted to measure success of this improvement. The results for March 2021 showed that there were no complaints raised in relation to medical and nurse practitioner services provided over the past six months and 100% of the care home residents are using Papamoa Beach Village contracted medical services.	delivery. The feedback from clients and families is positive, there have been no further complaints from any of the homes, and all clients have registered to receive care from the Papamoa Beach Village care home contracted GP and nurse practitioner.
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	CI	Metlifecare promotes no restraint use within its services and this has been effectively delivered as monthly surveillance across the company care homes evidences nil restraint use for over five years. This includes the Papamoa Beach Village, excepting the environmental restraint required for the secure dementia unit. Despite the Papamoa Beach Village facility reporting a high falls risk, which is also being addressed in a falls prevention initiative, there has not been any serious injury reports from the falls and the care team have not resorted to using restraint. Instead, a range of strategies have been implemented including ensuring the workforce is educated and well-trained from orientation onwards on restraint elimination and that this care home does not have restraint use. Ongoing systematic environmental checks are in place and any potentially unsafe aspect addressed immediately. Family members are informed of the restraint free environment and that there is no use of equipment or support of situations that have the potential to restraint a person or go against their will. This includes use of lap belts or bedrails, ‘making someone’ have a shower or a shave, change their clothing, go to the toilet, eat, drink, take medications, go to bed and get up. A brain health initiative was developed in April 2021 which aimed at increasing the education of the wider village residents and of families about dementia. This included that all staff become ‘dementia friends’ under the national dementia friendly initiative. The family education session has	Through implementation of a range of supportive and educational processes, the organisation’s philosophy and intention to eliminate the use of any enablers or restraints is being upheld in this facility. Evaluation and review processes confirm effectiveness of the strategies with no restraints or enablers having been used since it opened nearly two years ago.

		raised awareness of the value of a restraint free environment. An acute confusion screening/assessment tool guides registered nurses to consider delirium states and has contributed to the development of guidelines around supervisions and safety with residents with acute confusion. Measures of review and evaluation have included thorough investigations of all falls, the development of individualised strategies for falls prevention that do not include restraint use and routine review of falls data to identify areas for improvement. In addition to the ongoing environmental checks, residents' notes especially those with a high falls risk are scrutinised for risk factors and the restraint free environment is linked to the 24 hour activity plans. Reviews of events for behaviours of concern are undertaken to ensure there is evidence of good practice and preventive processes are considered. Staff have expressed pride for working in a restraint free facility in their feedback.	

End of the report.