Elmswood Court Lifecare Limited - Elmswood Retirement Village

Introduction

This report records the results of a Partial Provisional Audit; 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:

Legal entity:	Elmswood Court Lifecare Limited
Premises audited:	Elmswood Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 March 2024 End date: 12 March 2024

Proposed changes to current services (if any): A reconfiguration request was completed (15 December 2023) to notify of the intention to reconfigure 25 hospital beds to dual-purpose beds and 31 apartments (currently certified rest home level care) to dual-purpose beds. In summary, there will be 54 dedicated rest home beds and 56 dual-purpose beds. The total bed numbers remain at 110.

A partial provisional audit verified that the requested reconfiguration of requested bed numbers to be suitable as dual-purpose beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 45

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
	Includes commendable elements above the required levels of performance	All subsections applicable to this service are fully attained with some subsections exceeded
	No short falls	Subsections applicable to this service are 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 are partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some subsections applicable to this service are 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 are unattained and of moderate or high risk

General overview of the audit

Elmswood Retirement Village (Elmswood) provides rest home and hospital (geriatric and Medical) level care for up to 110 residents. The Quality and Risk committee provide governance for the organisation.

This unannounced surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Standard 2021 and contracts with Health New Zealand Te Whatu Ora Waitaha Canterbury. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family/whānau, management, staff, and a general practitioner.

A concurrent partial provisional audit was also undertaken to establish the level of preparedness of the provider to; (i). provide dual-purpose level care across 31 apartments (currently certified rest home level of care) and to (ii). provide dual-purpose level across 25 hospital beds. The partial provisional audit included interviews with management, staff, equipment, a visual inspection of the building, and reviewing relevant business documents including a transition plan and draft roster. This partial provisional audit verified that the 25 hospital beds and 31 apartments are suitable to provide dual-purpose level care. However, the service will only take up to 10 hospital residents at any given time in the apartments. Improvements are required around completion of refurbishments.

The day-to-day service is managed by a suitable qualified facility manager. The general manager oversees the implementation of the quality and risk programme. Residents and families/whānau interviewed spoke positively about the care and service provided. There has been a change in clinical manager since the last audit. Clinical oversight is provided by the qualified clinical manager,

supported by a unit coordinator and a quality consultant. There have been environmental upgrades and refurbishments completed since the last audit.

The surveillance audit identified one improvement required in relation to management of medication.

Ō tātou motika | Our rights

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 are fully attained.

Elmswood provides an environment that supports resident rights and 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. Staff demonstrate an understanding of resident's rights and obligations. A Māori health plan is documented for the service. This service supports culturally safe care delivery to all residents. Residents receive services in a manner that considers their dignity, privacy, and independence. The rights of the resident and/or their family/whānau to make a complaint is understood, respected, and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well-documented. A complaints management policy includes information on access to advocacy and complaint support systems.

Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Subsections applicable to this service are fully attained.

Services are planned, coordinated, and are appropriate to the needs of the residents. The organisational strategic plan informs the site-specific operations objectives which are reviewed on a regular basis. The quality improvement plan includes a mission statement and quality objectives. The service has effective quality and risk management systems in place that take a risk-based approach. Quality and risk performance is reported across various meetings. Elmswood collates clinical indicator data and benchmarking occurs.

There are human resources policies including recruitment, selection, orientation, and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service education/training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligned with contractual requirements and included skill mixes. There is a draft roster for staffing requirements to accommodate the increase in dual purpose beds. A comprehensive orientation programme is implemented.

Ngā huarahi ki te oranga | Pathways to wellbeing

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 are partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and family/whānau input. Care plans viewed demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals. Discharge and transfers are coordinated and planned.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants are responsible for administration of medicines. They complete annual education and medication competencies. The

electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner/nurse practitioner.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The service has a current food control plan.

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

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

A current warrant of fitness is in place and displayed. There is a planned and reactive maintenance programme in place. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Fixtures, fittings, and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. The call bell system is appropriate.

Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency including outbreaks. There is an approved evacuation scheme and emergency supplies for at least three days. A staff member trained in first aid is on duty at all times.

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

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.		Subsections applicable to this service are fully attained.

Infection prevention management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers.

Documentation evidenced that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. Antimicrobial usage is monitored. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to a quality and risk committee. The service has robust pandemic and outbreak plan. There is access to sufficient PPE supplies. There have been two outbreaks recorded since the previous audit.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. There is a laundry on site. Chemicals are stored safely throughout the facility. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services.

Here taratahi | Restraint and seclusion

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 are fully attained.

The restraint coordinator is the clinical manager. At the time of the audit there was no restraint in use. Strategies to eliminate restraints and managing distressed behaviour and associated risks are included as part of the mandatory training plan and orientation programme.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	20	0	1	1	0	0
Criteria	0	106	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. 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	The Māori Plan is documented to guide practice and service provided to residents at Elmswood Retirement Village (Elmswood). At the time of the audit there were no residents who identified as Māori. Interviews with the management team (general manager, facility manager, clinical manager) confirmed the service and organisation is focused on delivering person-centred care which includes operating in ways that are culturally safe. The service has provided training sessions on cultural safety/diversity and understanding bias in October 2023. Eleven staff were interviewed (four health care assistants (HCAs), three registered nurses (RNs), one rest home unit coordinator, one chef lead, one educator and a maintenance person) as part of the audit. The care staff interviewed described their commitment to supporting tāngata and future Māori residents and their whānau by identifying what is important to them, respecting their individual values and beliefs and enabling self-determination and authority in decision-making.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live	FA	The Pacific health plan incorporates the Pacific Health and Wellbeing Plan 2020-2025. A cultural awareness policy documents connectivity within the region occurs through their staff and Pasifika staff assist to increase

and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.		knowledge, awareness and understanding of the needs of Pacific people. Staff interviewed were knowledgeable around cultural preferences of residents who identify as Pasifika. At the time of the audit there were residents and staff who identified as Pasifika.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	Details relating to the Health and Disability Commissioners (HDC) Code of Health and Disability Consumers' Rights (the Code) are included in the information that is provided to new residents and their family/whānau. The clinical manager discusses aspects of the Code with residents and their family/whānau on admission. The Code is displayed in multiple locations in English and te reo Māori. The Code is also available in different languages if required. Three residents (two hospital and one rest home level resident in the apartments) and five family/whānau (two hospital and three rest home) interviewed reported that the service is upholding the residents' rights. Interactions observed between staff and residents during the audit were respectful.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	Elmswood policies guide expectations around ensuring that the service is free from any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. The facility manager interviewed stated there were no incidents of abuse reported. Cultural days are held to celebrate diversity. A staff code of conduct is discussed during the new employee's induction to the service, with evidence of staff signing the code of conduct document sighted in the staff files. Police checks are completed as part of the employment process. The service implements a process to manage residents' comfort funds. Professional boundaries are defined in job descriptions. Interviews with HCAs confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation.

Subsection 1.7: I am informed and able to make choices 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. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. 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 around informed consent. Resident files reviewed included completed general consent forms and consents for receiving and recording information, providing information, in relation to students/training, activity outings, taking of photographs, influenza and Covid-19 vaccinations. Family/whānau interviewed could describe what informed consent was and knew they had the right to choose. Consent forms were appropriately signed by the resident or enduring power of attorney (EPOA) where applicable. All documentation regarding enduring powers of attorney were on file.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. 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. 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 provided to residents and family/whānau during the resident's entry to the service. Complaint forms and a suggestion box are in a visible location at the entrance to the facility. Residents or family/whānau making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. The Code of Health and Disability Services Consumers' Rights and complaints process is visible, and available in te reo Māori, and English. The facility manager is maintaining a complaints register. There were two complaints in 2023 (since the last audit), and four entries made related to concerns and feedback that had been raised in an informal manner. Complaints reviewed, evidenced that all were resolved to the satisfaction of the complainants and closed off. The complaints reviewed have been acknowledged and addressed within the required timeframes and demonstrate management in accordance with guidelines set by the Health and Disability Commissioner. There were no complaints in 2024 year to date. Residents and family/whānau have a variety of avenues they can choose from to make a complaint or express a concern, including the resident and family/whānau meeting. Interviews with the general manager, facility

		manager and clinical manager confirmed their understanding of the complaints process. The facility manager reported the complaints process works equitably for Māori and guidelines are provided in the complaints policy, support is available when required, and there is an understanding that face to face meetings with whānau are preferred in resolving issues for Māori. Staff are informed of complaints (and any subsequent corrective actions) in the quarterly staff meeting (minutes sighted). Discussions with residents and family/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had in the past, were addressed promptly. One complainant interviewed stated their complaint was dealt with in an open, transparent, and swift manner.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. 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. 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	Elmswood Retirement Village (Elmswood) is privately owned by a company of three directors, one of whom is the general manager who works across two facilities (Elmswood and Fendalton Retirement Village), with both owned by the company. Elmswood is certified to provide hospital (geriatric and medical) for up to 110 residents. There are 79 care centre beds (54 rest home beds and 25 hospital beds) and 31 apartments certified to provide rest home level of care. There were 45 residents residing in the facility at the time of the audit including 23 at rest home level of care (including four in the apartments) and 22 at hospital level of care. All residents were on the age-related residential care contract (ARRC). There were no double or shared rooms in the care centre and no rest home couples in the apartments. The rest home level care building has been assessed for risk during an earthquake and approved as safe to occupy. In preparation for repairs as the result of the 2011 earthquake the Cedar wing (20 beds) has been closed and the service has stopped taking long term admissions to the other two wings (Rata and Kowhai). A reconfiguration request was completed (15 December 2023) notifying HealthCERT of the intention to reconfigure 25 hospital beds to dual purpose beds (hospital and rest home); and 31 apartments (under occupation Right Agreements [ORA]) currently certified for rest home level care to dual purpose beds. However, the service will only take up to 10

		hospital residents at any given time in the apartments. Overall, the dedicated rest home beds decrease from 85 to 54 and dual-purpose beds to increase to 56. The total bed numbers remain 110. The audit identified that the 25 hospital beds and 31 apartments, staff roster, equipment requirements, established systems and processes are appropriate for providing dual-purpose level care. The quality and risk committee is the governance group (oversight of clinical and operations) and there are monthly quality and risk meetings with attendees including the general manager, facility manager, Elmswood clinical manager, Fendalton unit manager, Elmswood rest home unit coordinator and contracted quality/risk consultant who is a registered nurse (RN). The general manager (GM) is responsible for the implementation of oversight of quality and risk activities across both facilities and chairs the quality and risk meetings. Clinical performance is discussed at the monthly quality and risk meetings. The governance group (quality and risk committee) supports residents and family/ whānau to participate in the planning, implementation, monitoring, and evaluation of service through feedback from residents meetings and through the complaints management process. The general manager (GM) is supported by a full-time facility manager (with previous aged care experience and a background in business management). The facility manager is non-clinical and has been in the role for two and a half years. A clinical manager with aged care experience has been in the role for a year, has overall responsibility for clinical operations across all facilities and is supported internally by the rest home and hospital unit coordinators and an experienced team of RNs and HCAs. A quality consultant is contracted to assist with planning, drafting and review of all policies and procedures. The clinical manager has completed comprehensive orientation to their role and completed the required leadership activities related to the clinical management of an aged care facility. The facility manager has completed the required professional development training related to their role. There is a strategic plan documented 2023-2025 and include mission, values, and philosophy along with goals documented. The quality improvement plan cascades from the strategic plan. There is a quality and risk report tabled at the quality and risk monthly meetings that identify outcomes for tāngata and Māori. The general manager interviewed

		confirmed their understanding of their obligation to comply with Ngā Paerewa NZS 8134:2021, including understanding of the services obligations under Te Tiriti, health equity, cultural safety and how the service improve outcomes to achieve equity for tāngata whaikaha, people with disabilities. Information pertaining to demographic data, barriers in access to outcomes for tāngata whaikaha is woven throughout organisational and operational documents. All members of the quality and risk committee have completed cultural training to evidence cultural competency. They are supported when required by a Māori advisor from Ngākau Aroha. Performance of the service is monitored through satisfaction surveys, clinical performance indicator data, staff incident reporting, internal audit results, the complaints process, and resident, family/whānau and staff input through feedback and meetings. The quality and risk report also includes clinical data, analysis and trends, health and safety information, information on staffing, outcomes of internal audits, progress on corrective actions. The goals relating to operational and clinical effectiveness, are clearly identified, monitored, and reviewed annually. The general manager confirmed the request for the reconfiguration of the 25 hospital beds are to assist their own village residents to transition into care and will not be advertised as rest home beds to the general public. The strategic plan allows for a phased approach to include the plans of bed configuration with minimal disruption for the occupants/residents. There are no changes to the governance structure as a result of the reconfiguration of the 25 hospital beds to dual purpose (hospital and rest home) and to the 31 apartments that have been verified as suitable as dual-purpose beds. The podiatry contract, physiotherapy contract, pharmacy contract and GP contract will remain unchanged.
Subsection 2.2: Quality and risk 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. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a	FA	Elmswood has a quality and risk management programme (called the quality improvement policy and plan). Quality goals for 2023 are documented and progress towards quality goals is reviewed annually by the quality and risk committee (governance). Goals set for 2023 have been reviewed as met and 2024 goals are set in the upcoming quality and risk meeting. The quality and risk management system includes performance

focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.		monitoring through internal audits and through the collection of clinical indicator data via the Vcare programme (including medication errors, falls, falls resulting in fractures, bruising, unintentional weight loss, consecutive weight loss for more than three months, skin tears, infections, restraint, and polypharmacy (nine medications or more). A range of meetings are regularly held, including quality and risk meetings, health and safety meetings, infection control and restraint meetings, clinical (RN and care leads) and staff meetings. Discussions include (but are not limited to) quality data, health and safety, infection control/pandemic strategies, complaints received (if any), staffing and education and cultural safety. Internal audits, 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 improvements are made and embedded into practice as a result of discussion and review of incidents, adverse events, complaints, and internal audits. Quality data and trends in data are posted for staff. The corrective action log is discussed at meetings to ensure any outstanding matters are addressed, with sign-off when completed. Data is benchmarked (using an Australian best practice target range tool for aged residential care) and analysed. The residents and family/whānau feedback is collated and discussed at quarterly meetings. Meeting minutes sighted evidence of a high level of satisfaction related to the service. Policies are available to all staff and changes to policies are communicated. A health and safety system is in place with identified health and safety goals. Hazard identification forms and an up-to-date hazard register were sighted. A risk register is placed in all areas. Health and safety policies are implemented and monitored monthly at the health and safety meeting. The health and safety reports are tabled at the quality and risk meeting (including representation of governance) for further discussions. There are regular manual handling training sessions for staff. The internal audit schedule includes health and safety, maintenance, and environmental audits which are included as part of the organisational management `facility check` audit. All resident's incidents and accidents are recorded, with data collated and analysed through the electronic system. Seven electronic resident incident forms reviewed evidenced immediate action noted and any follow-up action(s) required. Resident and family/whānau

		interviewed confirmed they are informed, and this was also evident in the resident files reviewed. Discussions with the clinical manager and facility manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There has been one Section 31 notification required to be completed for a pressure injury (since the last audit). HealthCERT was notified in relation to change in clinical manager in April 2023 (not sighted) and two events where the clinical manager covered a shift in the absence of a rostered RN. There has been one Covid-19 outbreak recorded in January 2024 and one viral gastroenteritis outbreak recorded in October 2023. The outbreaks were well managed and reported appropriately.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. 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. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	FA	There are three separate rosters: one for the 25-bed hospital area (Oak and Maple wing), one for the rest home (Cedar, Rata, and Kowhai) and one for the apartments. There was one wing (Cedar) as part of the 54 dedicated rest home beds out of commission due to awaiting completion of building repairs. The general manager also confirmed that any permanent admissions to the current dedicated rest home beds (across two other wings (Rata and Kowhai) are also ceased due to planning for future repairs to the building. Currently only respite admissions occur to the dedicated rest home rooms. Despite the closure of the Cedar wing, the rosters and staffing numbers have remained unchanged. Policy includes staff rationale and skill mix for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The clinical manager and rest home unit coordinator work full time from Monday to Friday. The clinical manager, the hospital and rest home RN unit coordinators, another RN and the quality consultant share the on call /afterhours support roster. Staff interviewed stated that the staffing levels are sufficient, there is cover provided for sickness and leave, and that the management team provide support. The service uses casual staff and agency staff to provide roster cover as needed. There is 24/7 RN cover. Family/whānau interviewed reported that there are adequate staff numbers.

		The annual training programme reviewed exceeds eight hours annually. There is an attendance register for each training session and an electronic individual staff member record of educational courses offered, including: in-services; competency and external professional development. All senior HCAs (care leads) and RNs have current medication competencies. There is a person with a first aid certificate on duty on all the shifts. All HCAs are encouraged to complete New Zealand Qualification Authority (NZQA) through Careerforce or NZ Tertiary College. Approximately 33 HCAs are employed and rotate between the hospital and rest home. Thirty-one HCAs have achieved their level three or higher level of certificate in health and wellbeing. Support with education and progression through the skills framework is supported by the career force assessor (RN). Staff completed cultural training as part of their mandatory training days. There is an educator/HR person on site (non- clinical) that support staff with their online training modules and ensure participation is encouraged. Registered nurses are supported to maintain their professional competency. There are implemented competencies for RNs and HCAs related to specialised procedures or treatments, including (but not limited to) infection control, wound management, medication management, syringe driver (RNs only) and insulin competencies. At the time of the audit there were 6 RNs employed at Elmswood and four RNs have completed interRAI training. There is an annual education and training schedule being implemented. All staff are skilled and qualified to work across all areas. The annual training programme evidence sufficient topics related to medical conditions across rest home and hospital level of care. The education and training schedule lists compulsory training which includes cultural awareness training. This includes staff completing a cultural competency. External training opportunities for care staff include training through Health NZ- Waitaha Canterbury and hospice. The Māori health plan includes objectives around establishing an environment that supports culturally safe care through learning and support. Staff are encouraged to participate in learning opportunities that provide them with up-to-date data and information on Māori health outcomes and disparities, and health equity. Staff confirmed that they are provided with resources during their cultural training. Māori staff also share information and whakapapa experiences to support learning about and

		address inequities. There are documented policies to manage stress and work fatigue. Staff could explain workplace initiatives that support staff wellbeing and a positive workplace culture. Staff are provided with opportunity to participate and give feedback at regular staff meetings, employee surveys and performance appraisals. Staff wellness is encouraged through participation in health and wellbeing activities and initiatives. Signage supporting organisational counselling programmes are posted in visible staff locations. Interviews with staff confirmed that they feel supported by their managers and workplace initiatives are encouraged. Partial provisional audit: This audit has verified the service as suitable to utilise the 25 hospital beds as dual-purpose beds and 31 apartments as suitable for dual purpose use. The general manager confirmed that the initial phase for the apartments will utilise only a maximum of five beds. There is a phased transition staffing plan to accommodate the changes in reconfiguration. The transition plan reviewed evidenced that no changes are required to the core staffing in the current hospital roster (25 beds) with the move to dual purpose beds. The general manager confirmed that the request for reconfiguration of the 25 hospital beds to dual purpose beds is to assist their own village residents to transition into care and will not be advertised as rest home beds to the general public. A draft roster was reviewed include a phased approach when residents in the apartments might become /change to hospital level care. The roster for the apartments will amalgamate with the rest home roster. The current apartment RN and hospital RNs resident ratio is considered appropriate to provide to support the initial introduction of resident hospital-level care, in particular the night shift. If numbers increase above 2 hospital-level residents in the apartment the RN hours per week will be increased for the apartments. The hospital and apartment wings are adjacent to one another and fully connected. There is RN cover 24/7. The draft roster takes into consideration the footprint of the apartments across three wings (Hagley, Avon, and Deans wing, all of which are the wings with apartments). There is a draft roster for one to two and three to five hospital level residents, and there are sufficient number of HCAs rostered to provide cultural and safe care for residents at

		a higher level of care. Activities staff, laundry and cleaning/household staff will remain unchanged for the initial phases of the transition plan.
Subsection 2.4: Health care and support workers 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. 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.	FA	Six staff files (one clinical manager, one RN, one chef lead, three HCAs) reviewed and evidenced completed orientation, training and competencies and professional qualifications on file where required. Annual appraisals have been completed for staff who have been employed for more than a year. There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A register of practising certificates is maintained for all health professionals. The service has an 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 and following a regular pattern of review thereafter. The service demonstrates that the orientation programme supports RNs and HCAs to provide a culturally safe environment for Māori. The HCAs interviewed reported that the orientation process prepared new staff for their role and could be extended if required. There is an appraisal register/schedule, and the schedule evidence appraisals are conducted annually as required. There are policies documented that guide good employment practices. There is no immediate recruitment required. Staff files evidence the appropriate training and skills required to provide for the higher level of care. Staff ethnicity is recorded in their file; staff files are kept secure, and resident information is password protected. The facility manager interviewed stated that following staff incidents, staff are debriefed and assisted to return to work in a safe manner. Partial provisional audit: The roster and staff files reviewed evidence staff skills, staff numbers, orientation, training, and education suitable to care for residents at a higher level of care. This audit has verified the staffing as suitable for the 25 hospital beds as dual-purpose beds and 31 apartments as suitable for dual purpose use.

Subsection 3.2: My pathway to wellbeing 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. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	FA	Five resident files were reviewed: three hospital level residents and two rest home residents including one residing in the serviced apartments. A registered nurse (RN) is responsible for conducting all assessments and for the development of care plans. There is evidence of resident and family/whānau involvement in the interRAI assessments and long-term care plans. This is documented in progress notes and all communication is linked to the electronic system. All residents have admission assessment information collected and an initial care plan completed within required timeframes. InterRAI assessments, re-assessments, care plan development and reviews have been completed within the required timeframes. These residents have a range of appropriate risk assessments completed. The electronic long-term care plan is holistic and aligns with the organisational model of care. A specific cultural assessment has been implemented for all residents. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans. Other available information such as discharge summaries, medical and allied health notes, and consultation with resident/relative or significant others form the basis of the long-term care plans. All residents had been assessed by a general practitioner (GP) within five working days of admission. The GP reviews the residents at least three-monthly or earlier if required. The GP interviewed provides after-hours support when needed and commented positively on the care, communication, and the quality of the service provided. Specialist referrals are initiated as needed. Allied health interventions were documented and integrated into care plans. A podiatrist visits regularly and a dietitian, speech language therapist, older persons mental health specialists and wound care specialist nurse is available as required through Health NZ – Waitaha Canterbury. The physiotherapist is contracted to attend to residents once a week. The health care assistants (HCAs) interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery; this was sighted on the day of audit. The HCAs complete task lists within the progress notes on every shift. The RNs document at least daily for hospital level and at least weekly and as necessary for rest home level care residents. There was evidence the RN

		has added to the progress notes when there was an incident or changes in health status or to complete regular RN reviews of the care provided. Residents and family/whānau interviewed reported their needs and expectations were being met. When a resident's condition alters, the RN initiates a review with the GP. The electronic progress notes reviewed provided evidence that family/whānau have been notified of changes to health, including infections, accident/incidents, GP visit, medication changes and any changes to health status. This was confirmed through the interviews with family/whānau members. There were thirteen residents with 18 wounds including one pressure injury and a surgical wound across both the hospital and rest home units. The current stage four facility acquired pressure injury has been notified to HealthCERT (sighted). Assessments and wound management plans including wound measurements and photographs were reviewed. An electronic wound register has been fully maintained. Wound assessment, wound management, evaluation forms and wound monitoring occurred as planned in the sample of wounds reviewed. The HCAs and RNs interviewed stated there are adequate clinical supplies and equipment provided, including continence, wound care supplies and pressure injury prevention resources. There is access to a continence specialist as required. Care plans reflect the required health monitoring interventions for individual residents. The HCAs complete monitoring charts, including observations, behaviour charts; bowel chart, blood pressure; weight, food, and fluid; turning charts, blood sugar levels, and toileting regime. The behaviour chart entries described the behaviour and interventions to de-escalate behaviours including re-direction and activities as evidenced in one file reviewed. Resident incidents are entered onto the electronic system and evidenced timely RN follow up. Neurological observations have routinely and comprehensively been completed for unwitnessed falls as part of post falls management. Evaluations are scheduled and completed at the time of the interRAI re-assessment. Written evaluations reviewed identify if the resident goals have been met or unmet. Long-term care plans had been updated with any changes to health status following the multidisciplinary (MDT) case

		conference meeting. Family/whānau are invited to attend the multi-disciplinary case conference meeting. Short term issues such as infections, weight loss, and wounds have a short-term care plan prepared with a trigger from the electronic programme if the issue is not resolved within 6 weeks. At this point the issues are then incorporated into the long-term care plan.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. 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.	PA Moderate	Policies and procedures are in place for safe medicine management. Medications are stored safely in a locked treatment room. HCAs and RNs responsible for medication administration complete medication competencies. All RNs are syringe driver competent. Staff have received training in medication management and pain management as part of their annual scheduled training programme. Ten electronic medication charts were reviewed and met prescribing requirements. Medication charts had photographic identification and allergy status notified. The GP had reviewed the medication charts three-monthly and discussion and consultation with residents and family/whānau takes place during these reviews and if additions or changes are made. Standing orders are not in use. All medications are charted either regular doses or 'as required.' Regular medications and 'as required' medications are delivered in blister packs. The RNs check the packs against the electronic medication chart and a record of medication reconciliation is maintained. Any discrepancies are reported back to the supplying pharmacy. Expired medications are returned to pharmacy in a safe and timely manner. There were three residents self-administering medications (two hospital and one rest home). The residents have medication competencies completed three monthly and medications are safely stored in their rooms. Residents who are on regular or 'as required' medications have clinical assessments/pain assessments conducted by a RN. All 'as required' medications had prescribed indications for use. The effectiveness of 'as required' medication had been documented in the medication system. The service provides appropriate support, advice, and treatment for all residents. Registered nurses and the GP are available to discuss treatment

		options to ensure timely access to medications. There is a medication room that stocks medication and wound supplies for the hospital unit. There is a separate medication room for the rest home and apartments. Medication fridge and room air temperatures are checked daily, recorded, and were within the acceptable temperature range. Medication rooms are accessible by door codes. There is sufficient Wi-Fi for the electronic medication process to occur uninterrupted. There is another secure medication room adjacent to a central nurses station that serves the rest home and apartments. A visual inspection of this medication room evident enough shelving and storage space for medications and wound care products. Medication room and fridge temperatures are recorded as required. There is sufficient bench space for the preparation of the medication and separate hand washing facilities within the treatment room. The medication policy identified that eye drops/creams and nasal sprays are to be dated on opening; however, on the days of audit this was not always evidenced. The RNs interviewed could describe medication process and informing residents and family/whānau of any changes to medications should this occur and explaining their medications to them. The clinical manager interviewed confirmed that all over the counter medications and supplements are considered by the GP when prescribing occurs. Partial provisional audit: There are sufficient numbers of RNs and senior HCAs deemed competent who are currently responsible for medication administration. There will not be any changes required to those who can administer medications with the changes to dual purpose configurations. The medication process, systems, and storage of medications for the 25-bed hospital will remain unchanged to accommodate the dual-purpose reconfiguration. In the apartments, there is a secure lockable `first aid` type cabinet that is intended to be used as a controlled drug safe in the medication room. The cabinet has been placed in an awkward position and is not sufficient for safe storage and handling of a larger number of controlled medications. There is one medication trolley in use and one in storage. The second

		trolley will be in use for the apartments as required. All other equipment for administration and management of medication is in place with no changes required due to the reconfiguration of dual-purpose beds. The current pharmacy contract will remain unchanged and will assist to support the service, tāngata whaikaha and Māori to access medication in a timely manner. The RNs described a process where they support Māori with understanding their medication and treatment options. The partial provisional audit verified that the medication service is suitable to provide for the change in the requested reconfiguration of beds.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	Food service policies and procedures include basic Māori practices respecting and supporting cultural beliefs, values, and protocols around food. The chef lead and a second chef oversee the on-site kitchen, and all cooking is undertaken on site. There is a seasonal five-week rotating menu, which has been reviewed by a dietitian. A resident nutritional profile is developed for each resident on admission, and this is provided to the kitchen staff. The chef lead interviewed stated they are involved in the activities theme months, particularly during cultural theme months and celebrations. The menu can be substituted to accommodate cultural meals in line with the theme and supporting residents to have culturally appropriate meals. The chef can cater for cultural needs specific to te ao Māori. The kitchen is able to meet the needs of residents who require special diets, and the chef (interviewed) works closely with the care staff on duty. The service purees foods on site to those residents requiring this modification. Lip plates and special utensils are available as required. The kitchen is situated adjacent to the rest home dining room. All staff have completed food safety training. The chef lead interviewed has knowledge of International Dysphasia Diet Standardisation Initiative (IDSSI). There are processes documented to involve residents and family/ whānau in the preparation of food as appropriate to the service. This include whānau rooms with small kitchenettes and kitchenettes in the dining room and communal spaces. There is a spacious dining room within the

		apartments and environment maintains dignity and is appropriate to meet their needs and cultural preferences. The dining areas are spacious for residents to move around with mobility aids and are directly off the servery area. There is safe access to all communal areas. Hospital level residents can also access the spacious dining room in the 25-bed hospital area. There is enough space to accommodate residents' mobility equipment. The draft roster documented evidence of sufficient staff to supervise and assist residents during mealtimes. Kitchen fridge, food and freezer temperatures are monitored and documented daily as per policy. The resident annual satisfaction survey template includes food service. The residents are to have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. The residents' dietary needs will be communicated to the kitchen as per policy. There is a current food control plan which expires on 2 March 2025. Partial provisional: The chef lead confirmed no changes to the food service would be required if the number of hospital or rest home residents changed. There is sufficient equipment currently to provide meals for up to 110 residents. Food is already transported in hotboxes (already plated) to the dining room in the apartment and 25 bed hospital and there would be no change if more or less residents were assessed at hospital or rest home level of care. There is a hot box available to keep meals warm for residents wishing to eat in their rooms. This partial provisional audit verified the food services to be suitable to accommodate the reconfiguration of beds.
Subsection 3.6: Transition, transfer, and discharge 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. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their	FA	Discharges or transfers were coordinated in collaboration with the resident and family/whānau to ensure continuity of care. Documented policies and procedures are in place to ensure, discharge or transfer of residents are undertaken in a timely and safe manner. The residents and their family/whānau were involved for discharges to and from the service. Discharge notes are uploaded to the system and discharge instructions are

transition, transfer, and discharge. 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.		incorporated into the care plan.
Subsection 4.1: The facility 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. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. 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.	PA Low	The facility is a single storey with 54 dedicated rest home beds across three wings : Rata, Kowhai and Cedar. Twenty beds in Cedar wing are currently unoccupied due to planned refurbishments. There is a newer extension to the building with 25 dedicated hospital level beds across two wings: Oak and Maple wing. The 31 apartments previously certified for rest home level of care are across three wings: Hagley, Avon, and Deans. There is a current building warrant of fitness that expires 1 April 2024 (one for the hospital and one for the rest home and apartments). A full-time maintenance person oversees the maintenance. The maintenance requests are logged, and records reviewed evidence requests are attended to in a timely manner Essential contractors such as plumbers and electricians are available 24 hours a day as required. An annual maintenance plan includes electrical testing and tagging, resident equipment checks, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. Testing and tagging of electrical equipment have been completed annually. Checking and calibration of medical equipment, hoists, ceiling hoists and scales is next due in September 2024. Residents are encouraged to bring their own possessions, including those with cultural or spiritual significance into the home and can personalise their room. The service has completed environmental upgrades to the apartment areas including furniture replacement, new call bell system, relevel flooring, drainage repairs, walls, and flooring refurbishment and ensuite upgrades. None of the changes required a change in the fire approved evacuation scheme. All bedrooms and communal areas have sufficient natural light and

		ventilation. There is underfloor heating in all areas including ensuite, and there are also heat pumps/ air conditioning units in the communal areas and every hospital wing bedroom. The temperature was a good ambient temperature on the day of the audit. Staff and residents interviewed stated that this is effective. There is a nurses station off Hagley wing (apartments) adjacent to the dining room for ease of supervision. All corridors have safety rails that promote safe mobility. Corridors are spacious, and residents were observed moving freely around the areas with mobility aids where required. Partial provisional: The hospital area is a newer extension to the main building (added on seven years previously). This audit verified that the 25 hospital beds in Maple and Oak wing to be suitable as dual purpose and 31 ORA apartments as suitable as dual-purpose. The 31 apartments are part of the main building; however, there is also a separate access to this part of the building from a parking area. Major refurbishments to the apartments were completed in December 2023. The 31 apartments have three separate lounge areas, small seating alcoves and a separate dining room. Two lounges provide sufficient space to accommodate activities whilst providing quieter spaces for other residents. The service has completed internal upgrades to the apartments in three wings (Hagley, Deans, Avon wing), except for the two apartments (410 and 411) in Deans wing where internal refurbishment/ furnishings is still ongoing. The two rooms are unoccupied currently until refurbishment is completed. External upgrades to the pathways and landscaping are ninety percent completed. There is safe access from apartment doors/sliders to the outdoors; landscaping has been completed in these areas. All outdoor areas provide for seating and shade. There is not yet safe access from the Penley lounge to the outdoors. Healthcare assistants interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of residents. There is plenty of storage space for equipment and continence products. There is a linen cupboard for the rest home and apartment area that is stocked daily. There is a room in the apartments that is intended to be used for linen that

		still needs shelving. The transition plan includes purchasing of more equipment if needed. There is a sling hoist for transfers. All rooms in the hospital wing have ceiling hoist available and the apartments are structurally ready for the placement of a ceiling hoist as residents transition to hospital level of care. There is sufficient equipment for the increase in hospital residents and a budget is available if more equipment is needed. All apartments are for single or couple occupancy and have individual ensuites. The space in the apartment and ensuite is sufficient to manoeuvre mobility equipment and hoist equipment with assistance of two staff. There were sufficient numbers of mobility, staff, and visitors' toilets and in close proximity to communal areas. Toilets are well identifiable and included privacy locks. Apartments identified as being able to currently cater for residents at rest home level of care were also verified as being appropriate and suitable for residents requiring hospital level of care. However, the apartment would only suit one hospital resident within the apartment if occupied by a couple. There are gloves, handtowels, alcogel and flowing soap accessible to staff. There is a transition plan documented to ensure there is further sufficient numbers of flowing soap, handtowels and alcogel in the hallways accessible for staff. All rooms including flooring are suitable for hospital level residents. There is a separate staff room. A nurse`s station is located in Hagley wing (apartments) and a secure treatment room is adjacent to the nurse`s station. The planning and refurbishment process included advice from Māori. There are no further plans for refurbishment to the apartment area.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or	FA	A fire evacuation plan is in place for the main building and the apartments that has been approved by the New Zealand Fire Service. Partial provisional: Emergency management policies, including the pandemic plan, outlines the specific emergency response and evacuation requirements as well as the duties/responsibilities of staff in the event of an emergency. Emergency management procedures guide staff to complete a safe and timely

unexpected event.		evacuation of the facility in the case of an emergency. The emergency planning includes business continuity plans in case of an emergency/disaster. There are no changes required to emergency management as a result of verification of the 25 hospital beds as dual-purpose beds and 31 apartments as suitable for dual purpose use. A fire evacuation plan is in place for the main building and the apartments that has been approved by the New Zealand Fire Service. A recent fire evacuation drill has been completed and this is repeated every six months. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Civil defence supplies(sighted) are stored centrally and checked at regular intervals. Evacuation lists with residents' mobility requirements are regularly updated and is documented in VCare. Call bells are suitable to summon health care staff. The fire evacuation scheme remains unchanged. There is an ambulance bay near the entrance. In the event of a power outage there is back-up power available. There are adequate supplies in the event of a civil defence emergency including water stores (tank water) to provide residents and staff with three litres per day for a minimum of three days. Emergency management is included in staff orientation and external contractor orientation and is included as part of the education plan. A minimum of one person trained in first aid is available 24/7. There are call bells in the residents' rooms and ensuites, communal toilets, shower rooms and lounge/dining room areas. Sensor mats are used for fall prevention management. These are audible and are displayed on attenuating panels in hallways to alert care staff to who requires assistance. Residents are provided with pendants if necessary. A resident in the serviced apartment interviewed confirmed that call bells are answered in a timely manner. The building is secure after hours and staff complete security checks at night. The front doors automatically lock at night. There are strategically placed closed circuit television within the building and outdoors. The partial provisional audit verified that the security and evacuation procedures are verified to be suitable to accommodate the reconfiguration of the beds required.

Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.	FA	Infection prevention and control (IPC) and antimicrobial stewardship (AMS) are an integral part of the Elmswood strategic plan to ensure an environment that minimises the risk of infection to residents, staff, and visitors by implementing an infection control programme. The organisation has personnel with expertise in infection control and AMS as part of their quality and risk committee (governance committee). Expertise can also be accessed from Public Health, and Health NZ-Waitaha Canterbury, who can provide with advice and resources. External resources and support are available through external specialists, microbiologist, GP, wound nurse, and Health NZ when required. Overall effectiveness of the programme is monitored annually by the quality and risk team. There is a documented pathway for reporting infection control and AMS issues to the quality and risk committee (governance). Outbreak of other infectious diseases is reported if and when they occur. Monthly quality and risk reports are completed. Monthly collation of data is completed, trends are analysed, and corrective actions are discussed for implementation at the clinical meetings, care lead meetings and quality and risk meetings. The general manager (who is a director) is part of the quality and risk meetings and receive information in relation to significant events. There are no changes to the governance structure in relation to infection prevention and control as a result of the reconfiguration of the 25 hospital beds to dual purpose (hospital and rest home) and to the 31 apartments that have been verified as suitable as dual-purpose beds.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. 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.	FA	The infection control programme links to the quality programme, infection data is collated, analysed, and reported on in meetings. Any infections of concerns are escalated to the quality and risk committee. The infection control programme is reviewed annually as part of the review of the quality improvement plan and occurred at the end of 2023. Infections are benchmarked. The infection control coordinator (clinical manager) is responsible for coordinating/providing education and training to staff. The orientation

As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.		package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff. Staff have completed infection control education in the last 12 months. The infection control nurse has access to an online training system with resources, guidelines, and best practice. The infection control coordinator oversees the infection control audits. A clinical manager oversees infection control and prevention across the service. The infection control coordinator has completed infection control training. The infection control coordinator has access to education and all organisational policies. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, pandemic and outbreak management plan, responsibilities during construction/refurbishment, training, and education of staff. Policies and procedures are reviewed by an external consultant with input from and approval by governance (quality and risk committee). There are documented policies and procedures in place that reflect current best practice relating to infection prevention and control and include policies for: hand hygiene; aseptic technique; transmission-based precautions; prevention of sharps injuries; prevention and management of communicable infectious diseases; management of current and emerging multidrug-resistant organisms (MDRO); outbreak management; single use items; disinfection of reusable medical devices/equipment, healthcare acquired infection (HAI); and the built environment. Infection prevention and control resources including personal protective equipment (PPE), were available should a resident infection or outbreak occur. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures. Elmswood has an organisational pandemic response plan in place which is reviewed and tested at regular intervals. The infection control coordinator, infection control committee have input when infection control policies and procedures are reviewed. Internal audits monitor the effectiveness of the implementation of the infection control programme, and these are discussed at the infection control meeting. The infection control committee and quality and risk committee are involved in procurement of good quality personal protective equipment

		(PPE) and work closely with contractors during the recent major refurbishments to mitigate noise and dust. The infection control nurse has access to an online training system with resources for Māori, other guidelines, and best practice. Staff completed cultural training to ensure safe practice related to all areas of service delivery. Staff interviewed stated they have access to sufficient PPE. At site level, the clinical manager has responsibility for purchasing consumables. All other equipment/resources are needed is discussed and approved by the quality and risk committee. Infection control related to construction, refurbishments, maintenance, and installations are discussed at relevant meetings including health and safety and infection control meetings. There is a policy in place for decontamination of reusable medical devices and this is followed. Reusable medical equipment is cleaned and disinfected after use and prior to next use. The service completed cleaning and laundry audits to safely assess and evidence that these procedures are carried out. Aseptic techniques are promoted through handwashing, sterile single use wound packs for wound management and catheterisations. The infection control coordinator and quality/risk consultant have completed infection control audits in August 2023 with corrective actions signed off on completion. There are no changes to implementation of the infection prevention and control programme as a result of the reconfiguration of the 25 hospital beds to dual purpose (hospital and rest home) and to the 31 apartments that have been verified as suitable as dual-purpose beds. The partial provisional audit also verified that the policies and procedures related to the infection prevention and control programme were sufficient to meet the requirements of the service delivery with the requested changes to dual purpose beds.
Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear	FA	There are approved policies and guidelines for antimicrobial prescribing. The antimicrobial policy is appropriate for the size, scope, and complexity of the resident cohort. Infection rates are monitored monthly and reported to the quality and risk meeting. Prophylactic use of antibiotics is not considered to be appropriate and is discouraged. Antibiotic use is reviewed monthly and reported at quality meetings.

and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.		Prescribing of antimicrobial use is monitored, recorded, and analysed at site level. The service monitors antimicrobial use through evaluation and monitoring of medication prescribing charts, prescriptions, and medical notes. Further discussion takes place at the infection control meeting, clinical meetings, staff meetings and reported to the quality and risk committee (governance). Trends are identified both at site level and national level. There are no changes to the monitoring activities related to the AMS programme in relation to infection prevention and control as a result of the reconfiguration of the 25 hospital beds to dual purpose (hospital and rest home) and to the 31 apartments that have been verified as suitable as dual-purpose beds.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. 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.	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. The infection control committee meets as part of the quality and risk meeting to discuss relevant policy changes, relevant education, audits, and any infection control concerns. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the individual resident infection register on the electronic system. Surveillance of all infections (including organisms) occurs; this data includes ethnicity and is monitored and analysed for trends. Benchmarking occurs monthly. Internal infection control audits are completed with corrective actions implemented for areas of improvement. Specifically with urinary tract infections, the service has ensured good practice such as extra fluid rounds, perineal hygiene practices and resident and staff education around prevention strategies. The service meets regularly with Health NZ- Waitaha Canterbury for support. Staff are informed of infection surveillance data through meeting minutes (RN meetings, staff meetings) and quality and risk meetings and notices. Residents and family/whānau are informed of infections and these are recorded in the progress notes. Infections, including outbreaks, are reported, and reviewed, so improvements can be made to reduce healthcare acquired infections (HAI).

		Since previous audit there has been one Covid-19 outbreak and one viral gastroenteritis outbreak. Outbreaks were notified to Public Health and have been well documented and managed. Outbreak meetings occurred and lessons learned were acted upon. Short-term care plans are developed to guide care for all residents with an infection. There are processes in place to isolate infectious residents when required. There are clear, culturally safe processes for communication between the service, residents, staff, family/whānau who experience a HAI. Hand sanitisers and gels are available for staff, residents, and visitors to the facility.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.	FA	Partial provisional: The facility implements a waste management policy that conform to legislative and local council requirements. Policies include (but are not limited to): considerations of staff orientation and education; incident/accident, and hazards reporting; use of PPE; and disposal of general, infectious, and hazardous waste. Current material safety data information sheets are available and accessible to staff in relevant places in the facility, such as the locked sluice rooms, laundry, and cleaner's room. Staff receive training and education in waste management and infection control as a component of the mandatory training. Interviews and observations confirmed that there is enough PPE and equipment provided, such as aprons, gloves, and masks. Interviews confirmed that the use of PPE is appropriate to the recognised risks. Observation confirmed that PPE was used in high-risk areas. There is a sluice room with stainless steel benches with hand sanitisers and adequate supplies of PPE, including eye wear. Cleaning services are provided seven days a week. Cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked room for the safe and hygienic storage of cleaning equipment and chemicals. Household personnel are aware of the requirement to keep their cleaning trolleys in

		sight. Chemical bottles/cans in storage and in use were noted to be appropriately labelled. Cleaning staff have completed chemical safety training. There is a locked/secure sluice with a sanitiser, handwashing facilities and PPE. There is not yet enough shelve space for an increased in linen (link # 4.1.2). There is access to hand sanitisers, flowing soap, and handtowels. The safe and hygienic collection and transport of laundry items into relevant colour containers was witnessed. Delicate resident's clothing and items are sorted and laundered on site. Linen, towels, other personal clothing, and mop heads are laundered in the main laundry that is operational seven days a week till 4.30 pm. Visual inspection of the on-site laundry (situated in Cedar wing in the rest home area) demonstrated the implementation of a clean/dirty process are suitable. Clean linen is transported in a covered trolley to the hospital and apartments. There is sufficient equipment to manage all laundry and cleaning duties/tasks. Residents' clothing is labelled, received in mesh bags, and personally delivered to their rooms. Residents and family/whānau confirmed satisfaction with laundry services in interviews and in satisfaction surveys. Any concerns that arise are immediately addressed. There is a policy to provide direction and guidance to safely reduce the risk of infection during construction, renovation, installation, and maintenance activities. It details consultation by the infection control and quality and risk committee. There was infection control advice evident in the recent construction and refurbishment. Infection control internal audits are overseen by the infection control coordinator.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the	FA	The restraint policy confirms governance commitment to aim for a restraint free environment and when restraints are used; that restraint consideration and application must be done in partnership with families/whānau, and the choice of device must be the least restrictive possible. At all times when restraint is considered, the facility will work in partnership with Māori, to promote and ensure services are mana enhancing. There were no residents using restraint at the time of the audit. The facility records reviewed the service to be restraint free since July 2023. The restraint coordinator (clinical manager) confirmed the service is

use of restraint in the context of aiming for elimination.		committed to providing services to residents without the use of restraint. Providing a restraint-free environment and managing distressed behaviour and associated risks is included as part of the mandatory training plan and orientation programme. All staff at Elmswood had completed restraint training and competencies in 2023. The care plan reviewed evidence cultural considerations and staff completed cultural training in 2023. There are no changes to the processes or use of restraint or to the commitment to a restraint free environment as a result of the reconfiguration of the 25 hospital beds to dual purpose (hospital and rest home) and to the 31 apartments that have been verified as suitable as dual-purpose beds.

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)
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	The RNs and medication competent HCAs are responsible for the administration of medications. Those responsible for medication administration have all completed medication competencies and education related to medication management. There is a policy and process on safe medicine management including reconciliation, storage, and documentation requirements. However, not all medications in current use were dated on opening where required. This included one eye crème and one nasal and four of eight midazolam sprays in in the hospital trolley. Partial provisional: A nurse’s station is located in Hagley wing and a secure	Surveillance: (i). Medication with a discard date after opening did not evidence dates on opening. Partial provisional: (ii). The current controlled medication cabinet is insufficient to safely store and promote safe handling of a larger number of controlled medications.	(i). Ensure all eye ointments, nasal sprays and midazolam sprays are dated on opening. (ii) Ensure the controlled drug safe is appropriate for safe storage and to promote safe handling of medications prior to occupancy. 60 days

		treatment room is adjacent to the nurse's station. The medication room has sufficient bench space and hand hygiene facilities. There is a secure lockable cabinet for controlled medication that does not provide sufficient safe storage or promotes safe handling of a larger number of controlled medications.		
Criterion 4.1.2 The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence.	PA Low	Partial provisional: The service has completed internal upgrades to the apartments in three wings (Hagley, Deans, Avon wing), except for the two apartments (410 and 411) in Deans wing where internal refurbishment/ furnishings are still ongoing. External upgrades to the pathways and landscaping are ninety percent completed. There is not yet safe access from the Penley lounge to the outdoors. There is safe access from apartment doors/sliders to the outdoors; landscaping has been completed in these areas. All outdoor areas provide for seating and shade.	Partial provisional: (i).The refurbishment (flooring and soft furnishings') of apartments 410 and 411 are yet to be completed. (ii). The landscaping and pathways outside Penley lounge are incomplete and safe access to the outdoors from this lounge is not yet provided. (iii) There is not yet enough shelve space for an increased in linen.	(i) Ensure to complete the outstanding refurbishment of apartment 410 and 411. (ii) Ensure safe access to the outdoors from Penley lounge. iii) Ensure there is sufficient shelving in the linen room. Prior to occupancy 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.

No data to display

End of the report.