Bethlehem Views Limited - Bethlehem Views

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 Health and Disability Auditing New Zealand 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:	Views Lifecare Limited
Premises audited:	Bethlehem Views
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: 15 October 2019 End date: 16 October 2019

Proposed changes to current services (if any): One resident room in the dementia care suites was assessed as suitable for a double room increasing the available beds in the suites from 20 to 21. The total numbers of beds available has increased from 88 to 89.

Total beds occupied across all premises included in the audit on the first day of the audit: 86

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

Arvida Bethlehem Views is part of the Arvida Group. The service is certified to provide rest home, hospital and dementia level of care for up to 89 residents. On the day of the audit there were 86 residents in the care centre.

This certification audit was conducted against the relevant Health and Disability Services Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relative, management, staff and the general practitioner

The village manager has been in the role three years and is supported by an experienced clinical manager, two clinical team leaders, training/health and safety coordinator and a stable workforce. They are supported by a management team at the support office and an Arvida national quality manager who was present during the audit.

The relatives, residents and general practitioner interviewed all spoke very positively about the care and support provided at Bethlehem Views.

There were no areas for improvement identified at this certification.

The service has been awarded a continuous improvement rating around communication, good practice and activities.

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.

Staff at Arvida Bethlehem Views strive to ensure that care is provided in a way that focuses on the individual, values residents' independence and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' individual cultural and spiritual needs are met including recognition of Maori culture. Care plans accommodate the choices of residents and/or their family/whanau. Policies are implemented to support residents' rights, communication and complaints management. Complaints and concerns have been managed and a complaints register is maintained.

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.

Arvida Bethlehem Views is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted which generates opportunities for improvement. Residents/family meetings are held regularly, and residents and families are surveyed annually. Meetings are held to discuss quality and risk management processes. Internal audits are completed, and corrective actions developed and implemented as required. Health and safety policies, systems and processes are implemented to manage risk. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant

information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed in the electronic resident records demonstrated service integration and were evaluated at least six monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and medication competent caregivers responsible for administration of medicines complete annual education and medication competencies. The medicine charts reviewed met prescribing requirements and were reviewed at least three monthly by the general practitioner.

The activity team provide and implement an interesting and varied integrated activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and resident preferences.

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

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.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness and ongoing maintenance plan in place. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. There is a mix of bedrooms with ensuites, and some bedrooms have shared toilets/showers. Rooms are personalised. 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. Staff have planned and implemented strategies for emergency management. There is a staff member on duty at all times with a current first aid certificate.

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.		Standards applicable to this service fully attained.

Arvida Bethlehem Views has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. During the audit there were no residents with restraint and four residents with enablers. Residents had voluntarily consented to using an enabler. The clinical manager is the designated restraint coordinator. Enabler assessments and evaluation processes were completed with the resident and reviewed three monthly.

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.

Infection control 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 evidences that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with care staff (10 caregivers, five registered nurses (RN), two clinical leaders and two diversional therapists) confirm their familiarity with the Code. Interviews with five residents (three rest home and two hospital) and eight family members (three rest home, two hospital and three dementia care) confirm the services being provided are in line with the Code. Training around the Code is provided as art of the education programme.
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	Informed consent processes were discussed with residents and families on admission. Written general consents for photographs, release of medical information, and medical cares were signed as part of the admission agreement (under permissions granted). A signed transport and outings indemnity consent form was sighted in the residents' files reviewed. Specific consent had been signed by resident/relatives for procedures such as the influenza vaccine. Discussions with staff confirmed they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' files and activated where required. The EPOAs in two of two dementia care files had been activated. Advance directives for health care including resuscitation status had been completed where residents

		were deemed to be competent. Where residents were deemed incompetent to make a resuscitation decision the GP had made a medically indicated resuscitation decision. There was documented evidence of discussion with the family. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services, including contact details is available in advocacy brochures. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. An HDC advocate provides annual in-service for residents and staff. Interviews with staff and residents/relatives informed they are aware of advocacy and how to access an advocate.
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 encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. Relatives interviewed stated they can visit at any time. There are community links with SPCA, pre-school and school age groups, Rotary club and churches.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission in the welcome pack. Complaint forms are available at the main entrance of the facility and in each wing and resident rooms. The village manager is the privacy officer and consults with the clinical manager for care related concerns/complaints. Staff are aware of the complaints process and to whom they should direct complaints. An on-line and hard copy complaint register is maintained. There have been two internal complaints, one in 2018 and two made in 2019 to date. The complaints reviewed had been managed appropriately with acknowledgement, investigations and resolved to the satisfaction of the complainant. Residents and families advised that they are aware of the complaints procedure and how to access forms. An HDC complaint in May 2019 is in the process of being investigated. The service has forwarded information as requested and is awaiting an outcome. The service responded to a different complaint July 2019 that was referred to the DHB from MOH. Corrective actions were put in place and the complaint closed out.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There are posters of the Code on display throughout the facility and leaflets are available in the entrance of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service the resident/family is provided with a welcome pack that includes information around the code of rights. The HDC advocate visits the service annually to provide information and promote discussion around the Code of Rights.
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	The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they maintain resident privacy and respect of personal property. Staff were observed knocking on resident doors before entering the room. Individual spiritual and cultural beliefs are identified during the admission process, documented in care plans and evaluated to ensure the residents needs are being met. Church services are conducted regularly. Rooms are blessed following death. Residents interviewed indicated that their spiritual needs are being met when required. Staff have completed abuse and neglect training.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has established cultural policies to help meet the cultural needs of its residents. The service has links with the local Iwi cultural advisors and Maori Health providers. Kaumatua are available to provide resident/whanau support and act as advisors for staff. There were two residents who identified as Maori on the days of audit. Maori Health plans were in place for the residents and identified the importance of whanau involvement/consultation in the resident's wellbeing. The Maori residents are encouraged to attend activities such as flax weaving and Maori cultural choir groups. The facility can convert a lounge into Marae style sleeping accommodation when required for whanau of terminally ill residents. Discussions with staff confirm that they are aware of the need to respond to cultural differences and the importance of family consultation and involvement.
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,	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan in consultation with the resident (as appropriate) and/or their family/whanau. Care staff interviewed could describe how they would communicate with non-English speaking residents with the use of body language and pictorial cards. Cultural diversity training has been provided.

spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents and relatives interviewed reported that the staff show respect towards them. Job descriptions include responsibilities of the position. The employee agreement and orientation provided to staff on induction includes standards of professional conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to complete orientation and complete the on-line training programme. There is clinical leadership team of experienced RNs (clinical manager and two clinical team leaders) to guide and mentor the RNs and caregivers. There is evidence of continuing best practice in clinical practice. There is good organisational support provided by Arvida general manager of wellness and a national quality manager both of whom are RNs. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. The Arvida group is implementing the living well model that includes five pillars of health, engaging well, resting well, eating well, moving well and thinking well.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	CI	Residents and relative interviewed stated they were welcomed on entry, received and information pack and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twenty-two incident/accidents reviewed had documented evidence of family notification. Families interviewed confirmed they are notified of any changes to their relative's health. There are monthly resident meetings held with the diversional therapists. The meetings are open to families. There has been very positive feedback from families who attend the Memory (dementia) Care suites family support meetings. Families are kept informed on facility events and receive feedback on survey results through regular newsletters. There are interpreters available as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services	FA	Arvida Bethlehem Views is owned and operated by the Arvida Group. The service provides rest home, hospital and dementia care level for up to 89 residents in the care centre. On the day of the audit, there were 86 residents in total. There are 68 dual purpose rest home/hospital beds and 21-bed dementia care suites. One room in the dementia care suite was assessed as suitable for a double room increasing the

are planned, coordinated, and appropriate to the needs of consumers.		number of beds from 20 to 21. On the day of audit there were 24 rest home residents, 41 hospital residents (including two younger persons with physical disabilities, one respite care resident and one resident under long-term say chronic health condition – LTS-CHC) and 21 dementia care residents. The village manager has been in the role three years and has 20 years' experience managing residential care homes and retirement villages. She is supported by an experienced clinical team and health and safety/training coordinator. The clinical manager has been in the role four years and has previously managed aged care facilities. The clinical manager is supported by two experienced clinical team leaders (one for rest home/hospital and one for dementia care suite). The management team are supported by the general manager of wellness and care and the national quality manager (who was on-site during the audit). Arvida has an overall business/strategic plan developed by the board and executive team at support office. The organisation vision, mission and values is included in the business plan. Arvida Bethlehem Views has a site-specific annual business plan around continuing to strengthen the goals of the living well model including a focus on men's activities and engaging with the community. The goals are evaluated regularly. There are informal weekly management meetings and a formal monthly quality risk meeting (heads of departments). The village manager provides fortnightly updates to support office and there are monthly zoom meetings with all village managers. The village manager has attended at least eight hours of professional development including attending the three-day annual Arvida managers forum which covered business planning, Living Well and health and safety, and has attended the living well leadership programme for trainers. The clinical manager has maintained clinical training and competencies and has attended the Arvida clinical manager forums. The two-day study day in March 2019 included quality/risk management, complaints management, clinical risk, emergency response, benchmarking and the living well model.
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 village manager, the clinical manager is in charge with support from the general manager of wellness and care at the support office. The clinical manager and clinical leaders share the on-call for clinical concerns. The village manager is on-call for non-clinical concerns.

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The village manager is responsible for providing oversight of the quality programme on site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. There is quality and risk management plan in place for 2019 with a focus towards falls prevention and management for high risk residents. The team has a positive culture of continuous improvement with many quality initiatives that have been implemented (CI 1.8.1.1). Facility meeting minutes (quality/risk and infection control, health and safety committee, staff and RN) evidence discussion around quality data. Data is collected in relation to a variety of quality activities including accidents/incidents, infections, concerns/complaints, pressure injuries, restraint, internal audits and corrective actions. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. Meeting minutes are available on the staff notice board. There is an internal Arvida audit schedule in place. Audits are allocated to the relevant person/group to complete. Where results are less than expected corrective actions are developed, communicated to staff and signed off when complete. Re-audits occur as required. Policies and procedures are developed and reviewed two yearly (or earlier as required) by the national quality manager. Input is sought from relevant staff. All policies and procedure are available to staff on the Arvida intranet. Staff are notified of any changes or reviews made to policies and procedures. Residents/relatives are surveyed annually to gather feedback on the service provided and the outcomes are communicated to residents, staff and families through resident and family meetings and the newsletters. The overall service result for the resident/relative satisfaction survey 2019 demonstrated an increased satisfaction for clinical care, food services and activities above the overall score across the villages. Health and safety goals are established and regularly reviewed. There is a health and safety/training coordinator employed for two days a week. She has completed up to stage 4 of health and safety training and attended a health and safety update in 2018. Risk management, adverse events, hazard register and emergency policies and procedures are implemented and are monitored by the Health and Safety Committee (representative of clinical, kitchen, laundry and maintenance areas) at the two monthly health and safety meeting. Meeting minutes and graphs are posted on the staff health and safety notice board. There are monthly zoom (teleconference) meetings with the national health and safety manager at support office with the village manager and maintenance manager (health and safety representatives). Staff receive health and safety training on orientation day and on-going as part of the annual training plan. The physio provides hoist and safe manual handling training. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls including sensor mats, sensor pads on beds, clutter free environment, good fitting footwear, physio assessments and close supervision.

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	There is an accidents and incidents reporting policy. The clinical manager investigates accidents/incidents and completes a monthly analysis of trends and any corrective actions/monitoring required. There is a discussion of incidents/accidents at quality risk, health and safety committee and staff meetings including actions to minimise recurrence. Twenty-two accident/incident forms were reviewed on the electronic register for September 2019 including falls (unwitnessed and witnessed, skin tears, bruises, absconding and near miss). A registered nurse (RN) conducts clinical follow up of residents following incidents including notification of relatives. Neurological observations had been completed for unwitnessed falls reviewed. Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 incidents reported for 2018 including one unstageable pressure injury (July 2018) and one stage three pressure injury (November 2018). Both pressure injuries were community acquired. A gastric outbreak was notified to Public Health April 2019.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources management policies in place. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. Eleven staff files were reviewed (one clinical manager, one clinical leader, one RN, one enrolled nurse, three caregivers, one diversional therapist, one chef, one cleaner and one maintenance). There is evidence that reference checks were completed before employment was offered. Performance appraisals were current in all staff files reviewed. A copy of practising certificates for qualified staff and allied health professionals is maintained. New staff attend a one-day orientation that provides new staff with relevant information for safe work practice including health and safety and infection control. Staff then complete their role specific orientation in their work area. Completed orientation was seen in the staff files reviewed. A training coordinator (previously an enrolled nurse) is employed for two days a week and coordinates the education programme and maintains staff education records. The education programme has been completed for 2018 and being implemented for 2019. Staff complete on-line (Altura) modules that cover the mandatory requirements. Planned "live" sessions are provided by external speakers such as hospice, pharmacist, laboratory, nurse practitioner and the contracted GP (Critical thinking for nurses). There are opportunities for staff to attend external education such as wound care, fundamentals of palliative care and dementia care provided by dementia care specialist. Staff complete competencies relevant to their role including medications, syringe driver, manual handling, male catherization, hand hygiene and van competency.

		There are 16 RNs. The clinical manager, two clinical leaders and eight RNs have completed interRAI training. Fourteen caregivers work in the dementia suite Nine caregivers have completed the required dementia suites standards. There are three caregivers in the process of completing the dementia unit standards and two newly employed caregivers yet to register. The training coordinator is a careerforce assessor.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Human resources policies include documented rationale for determining staffing levels and skill mixes for safe service delivery. There is one clinical manager and two clinical leaders (one for rest home/hospital and one for dementia care suites) who work Monday to Friday and are on-call. There are three dual purpose suites; Cambridge 25 beds, Sanderson 24 beds and Kaimai 19 beds. There is a 21 bed Memory (dementia) care suite – Eliza Benefell There is a RN in each dual-purpose suite on mornings and afternoons. One of the RNs is allocated to oversee the dementia care unit on afternoons. There are two RNs on night shift to oversee the service. There is at least one RN on duty at all times to cover for any RN leave/sickness. If required, the clinical manager or clinical team leaders provide RN cover and agency is available if required. There is a casual pool of nursing students. Caregiver staffing is as follow for each suite: Cambridge: 23 residents on the day of audit (12 rest home and 11 hospital). On the morning shift there four caregivers on full morning shift and on the afternoons four caregivers (one full shift and three who finish at 10pm). There is a caregiver “float” between the Cambridge and Sanderson suites from 10am - midday at other times as required. Sanderson: 24 residents (five rest home and 19 hospital including one respite). On the morning shift there four caregivers on full morning shift one caregiver on short shift until 1.45pm. On the afternoon shifts there are four caregivers on the full shift and an additional caregiver on Monday, Wednesday and Friday from 6-8.30pm to assist with evening showers. Kaimai: 18 residents (seven rest home and 11 hospital). On the morning shift and afternoon shifts there are three caregivers (full shifts). There is a caregiver on night shift in each dual-purpose suite. Eliza Benefell: 21 residents. There are four caregivers on morning shift with two on the full shift, one finishing at 2pm and the other at 2.15pm. On the afternoon shift there are four caregivers with two on the full shift, one finishing at 8.30pm and one finishing at 9.30pm. There are two caregivers on the night shift.

		The DT in the dementia care suite is on duty from 9am to 5pm. There is a DT for the rest home/hospital. There are support services staff for administration, food services, laundry, cleaning and maintenance.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Electronic residents' files are password protected from unauthorised access. Other residents or members of the public cannot view sensitive resident information. Electronic entries in records are dated, timed and identify the writer.
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.	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services are provided for families and residents prior to admission or on entry to the service. All resident files reviewed had signed admission agreements that aligned with contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.
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	There are policies and procedures in place for safe medicine management. Medications are stored safely in the four suites. Clinical staff who administer medications (RNs, enrolled nurses and medication competent caregivers) have been assessed for competency on an annual basis and attend annual medication education. Registered nurses and the enrolled nurses have completed syringe driver training. All medication (blister packs) are checked on delivery. Self-medication assessments and three-monthly reviews had been completed for those residents self-medicating. The medication fridge is checked as per policy, and temperatures are maintained within the acceptable temperature range. All eye drops sighted in the medication trolleys were dated on opening.

		Eighteen medication charts (paper-based) were reviewed and met prescribing requirements. Medication charts had photo identification and allergy status notified. The GP had reviewed the medication charts three monthly. 'As required' medications had prescribed indications for use. The pharmacist from the pharmacy that supplies Bethlehem Views was interviewed and commented favourably on the systems and processes in place for medication management.
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 services are overseen by a chef. All meals and baking are prepared and cooked on-site by chefs who are supported by kitchen assistants, morning and afternoon kitchenhands. All food services staff have completed food safety training. The Arvida seasonal menu had been reviewed by a dietitian. The cook receives resident dietary profiles and is notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated including food allergies and gluten free diets. The menu provides pureed/soft meals. The meals are prepared in the kitchen and transported in scan-boxes to the kitchenette bain maries, where they are then plated and served to residents in the dining room or their bedrooms. There are snacks available for residents in the dementia unit 24/7. The food control plan expires 14 June 2020. Freezer, fridge and end-cooked, re-heating (as required), cooling and serving temperatures are taken and recorded daily. All perishable foods and dry goods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Chemicals were stored safely. Residents provide feedback on the meals through resident meetings and resident survey. The cook receives feedback directly both verbally and through resident meetings. One day per week the chef spends times meeting with individual residents and the clinical manager / clinical team leader to discuss specific resident's dietary preferences and requirements. Residents and relatives interviewed spoke positively about the choices and meals 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	The reasons for declining entry to Bethlehem Views would be if the service is unable to provide the level of care required or there are no beds available. The service has a waiting list. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.

Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an admission assessment including relevant risk assessment tools. Risk assessments are completed six-monthly or earlier due to health changes. InterRAI assessments and long-term care plans were completed within the required timeframes. The outcomes of assessments are reflected in the needs and supports documented in the care plans on the electronic eCase system. Other available information such as discharge summaries, medical and allied health notes and consultation with resident/relative or significant others are included in the long-term care plans and resident electronic file.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans on the resident electronic system for all resident files reviewed were resident focused and individualised. Support needs as assessed are included in the long-term care plans. The eCase programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Care plans include the involvement of allied health to assist the residents in meeting their specific goals around wellbeing. Care plans identify current and acute needs such as (but not limited to); current infection, wound or recent fall. Short-term needs are added to the long-term care plan and removed when resolved. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, physiotherapy aide, podiatrist, community mental health services and palliative care nurse.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs are being well met. When a resident's condition alters, the registered nurse initiates a review and if required a GP is contacted. Care plans reflect the required health monitoring interventions for individual residents. A care activity worklog with scheduled tasks is generated for caregivers by the registered nurses. Monitoring charts including (but not limited to) repositioning, bowel chart, behaviour chart, food and fluid chart, weight, blood pressure monitoring, blood sugar levels, neurological observations and toileting regime are utilised. Monitoring charts are well utilised. Family are notified of all changes to health as evidenced in the electronic progress notes. Wound assessments, wound management plans with body maps, photos and wound measurements were reviewed on eCase. There were 30 wounds and two pressure injuries on the day of the audit. Wounds included two moisture associated skin damage; nine scrape / abrasions; nine skin conditions; six skin tears; two surgical wounds; and two venous ulcers. There was one resident with two stage two facility acquired pressure injuries on the day of audit, which were healing. There is access to the wound nurse specialists. Two of the registered nurses at Bethlehem Views also have a special interest in wound care, and the GP also oversees the care for most residents with wounds or pressure injuries.

		Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	The service employs two qualified diversional therapists and a physiotherapy assistant. One diversional therapist provides activities in the rest home / hospital and one diversional therapist provides activities in the memory care (dementia) suite. A recent initiative has been the appointment of a Moving Well Coordinator three days per week to enable implementation of a Moving Well Programme. In addition, volunteers assist with activities. Residents receive a copy of the activity programme which has the activities available each day. There are two separate activity programmes, one for the memory care unit, and one for the hospital and rest home. Activities are identified on the programme and held in the main lounge and memory care lounge. Activities are available to access in the memory care area for residents. A diversional therapist and / or caregiver facilitates activities in the memory care suite. One-on-one activities occur such as individual walks, chats, cooking and music occur for residents who are unable to participate in activities or choose not to be involved in group activities. The activity team provide individual and group activities that align with the Wellness model of thinking well, eating well, engaging well and moving well. These include (but are not limited to); breakfast clubs, daily exercise groups, quizzes, friendship club, sing a longs, dancing, bread making, cards and bingo, tai chi, cultural days and entertainers. Community visitors include volunteers, mums and bubs group, mainly music, church services, school children groups, Te Aranui Trust youth group and entertainers. There was evidence that the YPD residents had activities specifically catering for their needs, this included one to one music and cooking; and another resident was involved in group and community events. Activities have included a Men's Shed initiative; Virginal Café; mobile kitchen; increased van outings; and special invitation only morning teas and a Friendship Club. A resident leisure profile and map of life is completed soon after admission. Individual leisure plans were seen in resident electronic files. The activity coordinators are involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through resident integrated meetings (rest home and hospital) and surveys. The residents and relatives interviewed were happy with the variety of activities provided. There is a resident wellness committee and residents provide suggestions for activities and outings.
Standard 1.3.8: Evaluation Consumers' service delivery	FA	All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes in the

plans are evaluated in a comprehensive and timely manner.		electronic resident files reviewed. Family are invited to attend the multidisciplinary review meeting and case conference notes are kept on the electronic system. Evaluations reviewed, identified if the resident goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Six monthly case conference (MDT meetings) occur. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	There are documented policies and procedures in relation to exit, transfer or transition of residents. Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. There is evidence of referrals for re-assessment of service levels, such as rest home to hospital level of care.
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	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Cleaning chemicals are dispensed through a pre-mixing unit. Safety data sheets and product sheets are available. Sharps containers are available. Gloves and aprons are available for staff and they were observed to be wearing these as they carried out their duties on the day of audit. There are sluice rooms with appropriate personal protective clothing. Staff have completed chemical safety training by the provider of chemical supplies.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness which expires 11 April 2020. The maintenance manager works 35 hours per week, is available on call and is on the health and safety committee. There is a maintenance logbook in each nurse's station which is checked daily and signed off as repairs are completed. There is a planned maintenance schedule that includes resident equipment checks, calibrations of weigh scales and clinical equipment and testing and tagging of electrical equipment. Hot water temperatures are checked monthly and were below 45 degrees Celsius. There are preferred contractors available 24 hours for essential services. The corridors are wide and promote safe mobility with the use of mobility aids and for the use of hospital recliner chairs. Residents were observed moving freely around the areas with mobility aids. The external

		areas, courtyard and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. The dementia care unit has secure access. There is free access to safe outdoor gardens and walking pathways. One room in the dementia care suite has been assessed as suitable for a double room to accommodate a couple. There is sufficient space in the room to be able to mobilize with mobility aids if required and there is dual call bell access for the connection of sensor mat/bed sensor pad if required. Registered nurses and care staff interviewed stated they have adequate equipment to safely deliver care for rest home, hospital level and dementia level of care residents.
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	All resident rooms have full ensuites, with the exception of ten rooms that have shared ensuites. There are communal toilets within the facility with privacy locks. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is sufficient space in toilet and shower areas to accommodate shower chairs if appropriate.
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	There is one double room in the memory care suite. All other rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Dual purpose rooms had adequate space for the use of a hoist for resident transfers as required. Care staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
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	FA	There are two dining areas. One dining room area services rest home and hospital area residents; and one dining area services residents in the dementia suite. There is a large main lounge and a smaller lounge in the rest home / hospital area; and a lounge and quiet space in the memory care suite. There is safe access to the courtyard and gardens. All communal areas are easily accessible for residents with mobility aids.

dining needs.		
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	All laundry and cleaning is done on-site by dedicated laundry and housekeeping staff seven days a week. The laundry is divided into a “dirty” and “clean” area with an entry and exit door. Personal protective equipment is available. There is a central cleaner’s room where all trolleys are locked away when not in use. All chemicals on the cleaner’s trolley were labelled. Chemicals are stored in the cleaner’s rooms. There are safety data sheets and products guide available. Cleaning and laundry services are monitored through the internal auditing system and the chemical provider. The washing machines and dryers are checked and serviced regularly. Staff have completed chemical safety training. Residents and family interviewed report satisfaction with the cleanliness of the facility and the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan has been approved by the New Zealand Fire Service 22 December 2013. Six monthly fire evacuation drills are completed. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Emergency procedure flip charts are displayed in staff areas. Fire training and emergency situations/civil defence situations are included in the orientation day and as part of the training plan. Civil defence equipment (in locked cupboards) is located centrally and checked monthly. There is sufficient bottled water and food for at least four days per person. There is battery back-up for call bells and emergency lighting. There are barbeques for alternative cooking. Registered nurses complete first aid training ensuring there is at least one staff member on duty 24 hours with a first aid certificate. There are call bells in the residents’ rooms, toilet/showers and lounge/dining room areas. Residents in rooms were observed to have their call bells in close proximity. There is secure entry/exit to the memory care suite. The front automatic doors are automatically locked after hours. There is doorbell access for visitors after hours. The facility is secure after hours.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and	FA	All bedrooms and communal areas have ample natural light and ventilation. Air conditioners, gas fires and central heating are used to maintain a safe and comfortable temperature. The facility was maintained at a warm and comfortable temperature on the days of the audit.

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 infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. Infection control is linked into the quality risk and incident reporting system. The hospital clinical team leader is the infection control coordinator who oversees infection control management for the service. The infection control programme is reviewed annually at the infection control organisational meeting/education days. Visitors are asked not to visit if unwell. There are hand sanitisers strategically placed around the facility and adequate supplies of personal protective equipment available. Residents are offered influenza vaccinations.
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 designated infection control (IC) coordinator has been in the role since March 2019 and has a job description that defines the responsibility of the role. The infection control coordinator provides a monthly report for the quality/risk meeting. The IC coordinator is supported by the health and safety/training coordinator and infection control team which comprise of clinical and housekeeping representatives. There is support from the Arvida Group support office, GPs, nurse practitioner, laboratory, and the IC nurse specialist at the DHB. There are outbreak kits readily available. There are adequate resources to implement the infection control programme for the size and complexity of the organisation.
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	Arvida group infection control policies and procedures meet best practice. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Policies and procedures are reviewed at support office in consultation with infection control coordinators. Policies are available on the intranet.

Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan. Staff complete handwashing competencies. Resident education occurs as part of the daily cares.
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	Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on standard definition of signs and symptoms of infections. All infections are entered into the monthly online infection control register. This data is monitored and evaluated monthly for trends and analysed for opportunities for improvements. Analysis of infections and corrective actions are discussed at the quality meetings, clinical meetings and staff meetings. Topical events are discussed at handovers. Benchmarking occurs within the Arvida group and corrective actions required for any increase in infections outside of the Arvida benchmark indicators for infection types. Internal infection control audits are completed to monitor compliance against standards of practice. The GP reviews the use of antibiotics and all laboratory results. There has been one confirmed norovirus outbreak (April 2019). Public health was notified. Documentation including case logs and notifications to the public health were sighted. A post incident debrief, identified the outbreak was well managed and the service compliant with policies and procedures for outbreak management.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has policies and procedures in place to ensure the use of restraint is actively minimised. The clinical manager is the restraint coordinator. Restraint is used as the last resort. Care staff interviewed could describe alternative strategies used for falls prevention and de-escalating behaviours. On the day of audit there were no restraints and four hospital level residents voluntarily using enablers with one resident using two enablers (four bedrails and one wheelchair lapbelt). Enabler use is reviewed three monthly and evaluated six monthly as part of the care plan review. Restraint and enablers are discussed at the clinical and staff meetings. Staff education on restraint minimisation and management of challenging behaviour has been provided. Care staff complete restraint minimisation and safe practice competencies.

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	There has been continuous improvement evidence provided that demonstrates the service is committed to best clinical practice which is well embedded and supported by the GP and allied health professionals. These include manual lymphatic drainage treatment, RN respiratory clinical assessments, purchase of an anticoagulant monitoring machine and in-house phlebotomy service and nail spa therapy service.	The GP suggested lymphoedema massage and drainage for a resident. In March 2019 the clinical team leader sought the input of a lymphoedema therapist who assessed the resident and prescribed treatment. The therapist could visit every 2-3 weeks for a session. The RNs/enrolled nurses began specific education, including the use of on-line resources and a trial began with MLD twice daily and compression bandages and wraps, with oversight by the lymphoedema therapist. Monitoring included measuring the size of the leg daily, pain monitoring, wound healing, colour, warmth and capillary refill. After five months of treatment the lymphoedema therapist reduced the treatment to daily. Photographic evidence shows the size of the leg is back to normal size, there are no wounds and there have been no infections since the treatment began. The resident’s mobility and quality of life has improved. Due to the success of the treatment a RN will commence training as a lymphatic therapist in November 2019 and champion the treatment at Bethlehem Views for other residents as required. This will also result in timely treatment of residents requiring the treatment. 2)Registered nurse respiratory clinical assessments have improved through the

			use of high-quality stethoscopes and education and mentoring by the nurse practitioner and GP. Each RN was provided with a Littman stethoscope and attended in-service/power point session on clinical assessments by the nurse practitioner in January 2018. This included chest auscultation identifying normal chest sounds in comparison with abnormal chest sounds and the significance of low oxygen saturations, management and treatment. The nurse practitioner and GP confirmed chest sounds heard by RNs and provided a learning environment for RNs. Examples of RN clinical assessments documented in progress notes were reviewed and evidenced detailed respiratory assessments which were communicated to the GP. Diagnosis of chest infections and pneumonia have been made based on RN auscultation and description of chest sounds. As a result of this advanced clinical practice residents have been diagnosed and treated earlier for respiratory illnesses. 3) Provision of testing for INR at Bethlehem Views has been implemented to provide immediate INR results for medical review, mitigate multiple warfarin dose adjustments, provide improved therapeutic INR levels, minimise health and safety incidents for residents as a result of transportation to Pathlab and frequent venepuncture. Pathlab no longer provided rest home visits to take INR blood tests. A Coagucheck machine was purchased, staff were trained in its use, a drop of blood is extracted for use, test results are provided immediately to the GP and warfarin doses can be adjusted and therapeutic levels maintained. The outcome has been the ability to test INR levels more frequently to maintain accurate therapeutic levels of warfarin. The auditor sighted the use of the Coagucheck machine. Training RNs in the use of the Coagucheck machine occurred. There was evidence that residents would experience less discomfort from this procedure, as venepuncture is not required. Doses of warfarin are not changed as regularly as INRs remain closer to the therapeutic range. Clinical records for three residents on regular INR testing were sighted. The comfort to residents was increased as they are now able to access an in-house service. This service has been imbedded into clinical practice. The clinical manager is a trained phlebotomist and takes blood via venepuncture as required on GP request and transports the sample to Pathlab for processing. This additional service provided on-site provides a prompt venepuncture service and timely receiving of results. 4)The nail spa therapy service was created following family and staff concerns of inconsistent nail care. There had been an incident of missing jewellery and recognition that when a resident's condition deteriorates rings can become loose and lost. A new role was created and funded that was an extension to an

			existing HCA role with the intent of maintaining nail and hand care as well as checking and recording the resident's jewellery worn. This was completed monthly for all residents. There has been therapeutic value for all residents especially those with dementia from the sense of touch during the hand spa experience. There have been no incidences of skin tears from long fingernails and no family concerns relating to hand/nail care. Any loose rings noted is reported to the family members and addressed. There have been no further complaints of lost rings. The role has been sustainable and part of the living well model.
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	CI	The family support group meetings first commenced in 2015 and have continued to evolve into support mechanism for families to discuss and share their experiences. There has been very positive feedback from families which has ensured the success of this group.	Family support group meetings are held two monthly in a private lounge within the facility. These are held in the evenings to allow working family members to attend. The meetings are facilitated by the dementia care clinical team leader. An agenda is set and includes discussions from speakers and families sharing their experiences and an activity update from the DT. The agenda notes all discussions held at the meeting is kept confidential and is primarily a support network for families of residents living in the secure unit. There is a waiting list of residents for the dementia care unit and theses families are invited to attend the family support group meetings. Emails and letters (unsolicited) were sighted from family's members appreciative of the support of this "brilliant initiative". Two of three dementia care relatives state they attend the family group meetings and find they are very beneficial for support and networking within a family environment.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Activity groups have been developed as a result of resident's feedback and to align the programme to the Arvida's Living Well Model of Care. The activities programme was looking to replicate groups as would occur in the community at large. The vision was to create opportunities to promote independence, cater to individuality and facilitate engagement between	The service has implemented projects/activity groups as a result of resident feedback. (i) Numbers attending these new activity groups has increased significantly. A Men's Shed was built with input from Mitre 10 and the Men's Shed at the Historic Village. Twelve percent of the residents attend this, and attendees include males and females. The Virginal Café was created and a mobile kitchen with a benchtop oven was purchased. Thirty-five percent of residents have participated in the Virginal Café. Residents are able to cook what they would like and have a special meal event. A new larger van fit for purpose was purchased, van outings have increased and numbers attending van outings have increased. Residents are now able to enjoy walking through the nearby

		like-minded residents by offering a range of diverse choices of interest groups and different activities. Activities groups include the Men's Shed; Café; mobile kitchen; van outings; Friendship club; and special invitation only morning teas. Collaboration with Tauranga City Council has resulted in construction of a walkway linking a neighbourhood reserve to Bethlehem Views. There has been creation of a dedicated Moving Well Programme to meet the organisational goals of the Living Well Model of Care. A Moving Well Coordinator was appointed in November 2018 and an additional 8 hours was approved due to the success of the model and the role is now three days per week.	reserve due to the walkway constructed in partnership with Tauranga City Council. Special invite – only morning teas were held to enhance conversation. Attendance data was recorded in charting on e-Case. Photographic evidence demonstrates residents participating in the Men's Shed activities, Virginal Café and evidence of food that had been prepared in the mobile kitchen. All programmes have exceeded expectations and are sustainable, supported and resourced by senior management. (ii) The Moving Well programme has been integrated into the activities programme; new activities have been introduced including walking groups (residents walk around local walkways and streets); residents are reportedly now walking longer distances; men's exercise groups; gym classes (three to four residents participate); more residents going on bus outings into the community; more one-on-one strengthening workouts and greater participation in group exercise; and two residents being taken to aquarobics / swimming. Photographs sighted on the audit demonstrate evidence of residents participating enthusiastically in the Moving Well programme. Exercise classes were previously held four days per week and are now held five days per week, with a change of start time at 11.30am. Numbers of attendees to the exercise groups have increased from 12-15 attendees to up to 30 attendees. Resident and family interviewed confirmed there was an increase in satisfaction around recreational activities. The April 2019 survey results for activities was above the Arvida overall rating for activities.

End of the report.