

The Wood Lifecare (2007) Limited - The Wood Lifecare

Introduction

This report records the results of a Surveillance 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 BSI Group New Zealand Ltd, 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:	The Wood Lifecare (2007) Limited
Premises audited:	The Wood Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 March 2021 End date: 11 March 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	83

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
Yellow	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
Red	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

The Wood Lifecare is owned and operated by the Arvida Group. The service provides rest home and hospital level of care for up to 76 residents in the care centre and 36 residents at rest home level in the serviced apartments. On the day of the audit there were 83 residents.

This unannounced surveillance audit was conducted against a sub-set of 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, family, management, staff and the general practitioner.

The service is operated by a village manager who has been in the role for four years. He is supported by a clinical manager who has been in the position for three years and two clinical leaders. The village manager and clinical manager are supported by a national quality manager.

Four of five findings from the previous certification audit relating to assessments, self-medicating, restraint evaluation and infection control have been addressed. There continues to be a shortfall around timeframes.

This surveillance audit identified areas for improvement around implementation of care.

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.		Standards applicable to this service fully attained.
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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.
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The quality and risk management programme includes service philosophy, goals and a quality/business planner. Meetings are held to discuss quality and risk management processes. Residents/family meetings are held regularly, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Falls prevention strategies are in place that includes the analysis of falls incidents. An education and training programme is being implemented and includes competencies. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. An integrated activity programme is implemented for residents. Residents and families reported satisfaction with the activities programme. Medication policies and procedures are implemented. Staff responsible for administration of medicines complete education and medication competencies. The medicine charts were reviewed at least three-monthly by the general 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.

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.
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The building has a current building warrant of fitness. Preventative and reactive maintenance occurs. The facility is spacious and provides easy access to all communal areas. Outdoor areas are well maintained and provide seating and shade.

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.
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The Wood Lifecare has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were no residents using restraint and seven residents using enablers. Assessments and consents were fully completed. The clinical manager is the designated restraint coordinator. The restraint committee reviews restraints and enabler use. Staff receive training around restraint minimisation and challenging behaviours.

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.
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A registered nurse is the infection control coordinator, who is supported by the clinical manager. 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. Surveillance data is reviewed and discussed with the infection control committee. Covid-19 was well prepared for. Policies, procedures and the pandemic plan have been reviewed to include Covid-19. Wellness declarations are completed by all visitors and contractors entering the facility.

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	0	17	0	1	1	0	0
Criteria	0	44	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)
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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>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 via the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. Six complaints have been received at The Wood Lifecare since the last audit. The complaints reviewed had been managed appropriately with acknowledgement, investigations and responses recorded. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Five residents (two rest home and three hospital level, including two YPD) interviewed, stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident. Full and frank open disclosure occurs. Twelve incident/accidents reviewed for January and February 2021 had documented evidence of family notification where required. Three relatives (two rest home and one hospital level) interviewed stated that there are regular meetings to discuss any changes or concerns in their family member's health status. Interpreter services are available as required. Admission agreements were in place for the resident's files reviewed. The admission agreement contains a page with</p>

<p>conducive to effective communication.</p>		<p>information on premium rooms, and charges. Relatives are informed of changes following GP reviews and are invited to annual care plan reviews. In the resident files reviewed there was evidence in the progress notes around relative's notification of changes, meetings with relatives and the GP, and any changes in resident status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Wood Lifecare is owned and operated by the Arvida Group. The service provides care for up to 112 residents across 30 rest home beds, 46 hospital level beds (including six dual-purpose beds) and 36 serviced apartments certified to provide rest home level care. Two rest home beds have been changed to serviced apartments since the last audit. At the time of the audit there were 83 residents in total; 39 rest home residents including one resident on an LTS-CHC contract, one resident on a mental health contract and one resident on respite; 35 hospital residents including two residents on younger persons with disabilities (YPD) contracts, one resident on a mental health contract and one resident on an ACC contract. There were nine rest home residents in the serviced apartments. All other residents were admitted under the age-related residential care (ARRC) contract. There are six dual-purpose beds in the hospital area.</p> <p>The village manager has been in the role for four years. He is supported by a clinical manager who has been in the position for three years and the two clinical leaders. The village manager and clinical manager are supported by the Wellness and Care team. The village manager reports to the head of wellness and operations on a variety of operational issues and provides a monthly report.</p> <p>Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. The Wood Lifecare has a business plan for 2020–2021. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually. Fortnightly zoom meetings are held between the village manager and support office.</p> <p>The village manager and clinical manager have completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management</p>	<p>FA</p>	<p>There is a business/strategic plan that includes strategies for The Wood Lifecare that link to the overall Arvida goals/strategies. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager and clinical manager are responsible for providing oversight of the quality programme, which is also monitored at an organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. Arvida Group policies are reviewed at least every two years across the group. The service policies and processes meet relevant standards and links to their electronic system. Data is collected in relation to a variety of quality activities and an internal audit schedule is being completed. Areas of non-compliance identified through quality activities are actioned for improvement.</p> <p>Staff interviewed could describe the quality programme corrective action process. There are various monthly</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>meetings across the village including (but not limited to) RN/clinical meetings, staff meetings, quality meetings, health and safety meeting, and community and wellbeing meetings. Quality data is shared and is reported through all relevant meetings. Corrective actions identified are shared with staff through meetings, message board on eCase and reports. The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. The monthly village manager reports include complaints. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p> <p>A resident/relative satisfaction survey was completed in February 2021. The net promoter score between the 2020 and 2021 survey increased from 43 to 83. There is a quarterly resident/family meeting. The service has a health and safety management system that is regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the Health and Safety Committee that meets monthly. The administrator/receptionist is the health and safety coordinator and has completed stage one health and safety training. Hazard identification forms and an up-to-date hazard register are in place, which were last reviewed in September 2020. Falls prevention strategies are implemented including identifying residents at higher risk of falling and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. A monthly analysis is completed by the clinical manager. There is a discussion of incidents/accidents at meetings. A RN conducts clinical follow-up of residents. Twelve incident/accidents were reviewed and demonstrated that appropriate clinical follow-up and investigation occurred following incidents. However not all neurological observations were recorded and completed according to policy for any unwitnessed falls with potential for a head injury (link 1.3.6.1).</p> <p>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 incident notifications completed since the last audit, for one stage 4 pressure injury in February 2021 and one unstageable pressure injury in February 2020.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires relevant checks are completed to validate the individual's qualifications, experience and veracity. Seven staff files were reviewed, including one clinical leader (hospital), one registered nurse (RN), four wellness partners (caregivers) and one wellness leader. There is evidence that reference checks were completed before</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>employment was offered. Residents are involved on interview panels when interviewing for new staff. Annual staff appraisals were evident in all staff files reviewed. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The service has introduced a one-day induction and a minimum of three days orientation for all new staff that provides them with relevant information for safe work practice.</p> <p>Completed orientation is on files, and staff described the orientation programme. The in-service education programme for 2020 has been completed and 2021 (YTD) is being implemented. Self-directed learning sessions online through Altura are also being completed. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the district health board (DHB). Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours plus of staff development or in-service education has been provided annually. There are 50 caregivers in total. Completed Careerforce training as follows; 27 have completed level four, eight have completed level three and nine have completed level two training. There are nine RNs and two have completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The Wood Lifecare policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 123 staff in various roles including casual staff. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager (who is a registered nurse) and clinical manager work 40 hours per week from Monday to Friday and are available on call after hours. In addition to the village manager and clinical manager there are two clinical leaders (one for the rest home and hospital). There is at least one RN on at any one time. Extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirmed there are sufficient staff to meet the needs of residents.</p> <p>In the hospital area (35 hospital residents and 10 rest home residents), there is one clinical leader and one RN on duty on the morning shift, one RN on the afternoon shift, and one RN on night shift. They are supported by ten caregivers (five long and five short shifts) on the morning shift, eight caregivers (three long and five short shifts) on the afternoon shift and three caregivers on the night shift.</p> <p>In the rest home area (29 rest home residents), there is one clinical leader and one RN on the morning shift and one RN on the afternoon shift. They are supported by five caregivers (two long and three short shifts) on the morning shift, four caregivers (two long and two short shifts) on the afternoon shift and two caregivers on the night shift. The RN from the hospital supervises the rest home level area on the night shift.</p> <p>In the serviced apartments (nine rest home residents) there is one caregiver on duty on the morning shift and one caregiver on duty on the afternoon shift. The rest home staff supervise the rest home level care residents in serviced apartments after 9.30 pm.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Clinical staff who administer medications (RNs, enrolled nurses and medication competent caregivers) have been assessed for competency on an annual basis. Annual education around safe medication administration has been provided. All staff who administer medications have a current competency in place. Registered nurses complete syringe driver training. Medications are stored securely in line with current guidelines. Delivery of robotic packs are checked against the medication charts and recorded in the electronic medication system once completed by the RNs. All eye drops, and ointments sighted were dated on opening.</p> <p>Medication room, controlled drug room, medication fridge and specimen fridge temperatures are recorded daily and were all within expected ranges. The service has implemented an electronic medicine management system. Twelve electronic medication charts were reviewed across the rest home/hospital and serviced apartments. All had photo identification and had been reviewed by the GP at least three-monthly. 'As required' medication had indications for use documented. There was one resident in the rest home community who self-administers medications. There was a self-medicating competency in place. The previous finding has been addressed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a centrally located commercial kitchen in the facility. All food and baking is prepared on site by the kitchen team. There is a current food control plan in place expiring on 14 June 2021. There is an organisational menu in place which has been reviewed by a dietitian. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. Special diets were noted on the kitchen noticeboard. The kitchen manager interviewed was knowledgeable around resident preferences, likes and dislikes. Alternatives and dietary supplements are available. The main meal is at lunchtime. There is soup and two options available for tea. Special diets, and resident requests are accommodated. The kitchen manager attends the eating well meeting in line with the Arvida Pillars of care. Feedback is received, and the menu can be altered to swap meals for resident's dislikes.</p> <p>The resident wellness advocate for eating well was interviewed, and was passionate around meeting the dietary needs of the residents and collates feedback from residents around food services and presents this at the Eating Well meeting. Freezer, chiller and fridge temperatures are recorded daily. Temperatures are checked on receiving cold foods, and at end cooking. Temperatures of bain maries are checked. Cleaning schedules are maintained. There is a total of five satellite kitchens throughout the facility. Fridge temperatures were checked and within ranges, and cleaning schedules were maintained for each kitchenette area. The hospital dining area is under renovation to provide a satellite kitchen, where food can be served from the servery. Dining areas are spacious and light and provide adequate room for residents with mobility aids. Residents and relatives interviewed, overall stated satisfaction with the food.</p>
<p>Standard 1.3.4:</p>	<p>FA</p>	<p>A suite of assessments are available on the electronic system to be utilised according to resident need. The RN completes initial assessments on the electronic system on admission, which include risk assessments. All long-term</p>

<p>Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>resident files reviewed identified interRAI assessment notes and summaries were available. The outcomes of assessment tools are linked to the long-term care plan. All residents have falls risk assessments completed as per policy; the previous finding has been addressed. Post falls assessments are also completed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence in the electronic file that evidences relatives were notified of any changes to their relative's health including (but not limited to): accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Pain charts were in use for residents on PRN pain control medication. Interventions for short-term needs are added to the long-term care plan and resolved once the acute issue has resolved, or interventions remain on the long-term care plan if the issue continues.</p> <p>Overall, the care plans documented were resident focused; however, not all care plans included interventions to support current needs of the resident.</p> <p>The RNs interviewed described having access to specialists including the hospice, district nurses, wound care specialists, continence service and the stoma nurse, and Arvida nurse specialists. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. There is dietitian involvement where required.</p> <p>There were nine wounds in the rest home community, and 17 including chronic ulcers, skin tears, abrasions and lacerations in the hospital community. There were two stage 2 and one stage 1 pressure injuries in the hospital community. All skin tears were categorised. All wounds had individual assessments, wound management plans and evaluations in place. Photos were taken at regular intervals to evidence progression or deterioration of the wound. The wound care specialist has had input with chronic wounds as required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Monitoring occurs for weight, blood pressure, behaviour, wounds, blood sugar levels, pain, neurological observations, food and fluid charts; however, not all neurological monitoring was recorded according to policy. These were sighted across the files reviewed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as</p>	<p>FA</p>	<p>The service employs one qualified diversional therapist (DT), and a wellness leader. Activities are scheduled across five days. The wellness team share time between the rest home and continuous care (hospital) wing (CCW). The wellness team completes an activity profile/assessment on admission and develops/has input into two sections of</p>

<p>part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>the electronic care plan 'in leisure and pastoral care'. A monthly planner is developed with resident suggestions included. The planner includes Tai Chi as part of the continued fall prevention programme, group games, music and tech continues with students visiting to teach residents around technology (one-on-one sessions), exercises, reminiscence, and happy hours. The comfort trolley is still in place and continues to be well utilised for palliative care relatives.</p> <p>The Wood Lifecare has implemented the wellness/household model. The wellness/household model focuses on the relationship between the care team and the resident as partners in the pursuit of a rich and meaningful life. There is a resident representative for each pillar of the model. The 'eating well' resident representative was interviewed and described presenting resident feedback around food services at the eating well meeting held, where the kitchen manager attends.</p> <p>Residents from the serviced apartments are involved in making 'welcome packs' for new residents. The packs include toiletries, tissues, and some other 'bits and pieces' according to gender. One resident is present at the entrance of the facility to greet the new resident on arrival, where they introduce themselves, present the new resident with their gift, and make the resident (and relatives) feel comfortable.</p> <p>Resident meetings are held two-monthly with the clinical leader from the rest home and hospital and management attend. There is a separate community wellbeing meeting held where residents and wellness staff have the opportunity to discuss issues, suggestions and concerns specific to their community/household.</p> <p>Younger residents at The Wood Lifecare are encouraged to be as independent as possible (as are all residents) in the community. The wellness team are available to drop residents off at the mall and then pick them up later. Residents access the community independently with motorised scooters. A group of volunteers are currently in training to learn how to take residents out into the community.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>InterRAI re-assessments have been completed six-monthly in support of reviewing the care plan. Each section of the care plan is evaluated as care needs change and six-monthly, however, this is not always completed within timeframes (link 1.3.3.3). Evaluations are documented on the electronic system. Relatives interviewed confirmed they are invited to attend the six-monthly MDT review (case conference) and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes and long-term care plans updated (link 1.3.6.1). Changes to the electronic long-term care plan identify name and date to reflect the update. Residents and relatives interviewed confirmed involvement in the care planning and evaluation process.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 4 August 2021. The maintenance person (interviewed) ensures daily maintenance requests are addressed and a planned maintenance schedule is</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>maintained that includes internal and external building maintenance. An external contractor completes annual calibration, electrical testing, and functional checks of medical equipment. Hot water temperatures in resident areas are monitored and maintained below 45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to mobilise safely within the facility. There is a lift between floors which is large enough for a stretcher as needed. All communal areas are easily accessible and provide space for residents to move around freely with mobility aids. The outdoor areas are well maintained with seating and shade provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver resident cares.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>FA</p>	<p>The Arvida infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The infection control programme is reviewed annually. A RN is the designated infection control coordinator with support and supervision from the clinical manager and advice from the Arvida support office. The infection control committee comprises of the infection control coordinator, clinical manager, both clinical leads, kitchen manager, head of household department, and a caregiver. The previous finding has been addressed. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided via the online education programme for all new staff on orientation.</p> <p>There have been no outbreaks since previous audit. Covid-19 was well prepared for. Wellness declarations remain in place to be completed by all visitors and contractors visiting the facility. Red and green zones were identified in the facility which would be colour coded with coloured tape to define zones. Outbreak kits were reviewed and are in place in both the rest home and hospital areas. Zoom meetings were held frequently. Staff work in households which became bubbles. Training was provided around Covid-19, isolation procedures, donning and doffing personal protective equipment and handwashing.</p> <p>Two outbreak kits (one for each area) were made up for various types of precautions including droplet, contact, airborne and standard precautions. Information around guidelines and procedures for each level of lockdown is easily accessible to RNs. A 'rapid response' team of volunteers has been developed including the clinical manager and village manager who would be able to keep the facility running if there was a Covid case within the facility where staff had to isolate. All policies, procedures and the pandemic plan have been reviewed to include Covid-19. Adequate supplies of centrally located personal protective equipment were sighted.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Infections are entered into the infection register on the electronic data base. Monthly infection data is collected for all infections based on signs, symptoms and definition of infection. This data is monitored and analysed for trends monthly by the infection control coordinator and the clinical manager. Infection</p>

<p>out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>control surveillance is discussed at the RN meetings. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has documented systems in place to ensure the use of restraint is actively minimised. The facility is currently restraint-free. Enabler use is voluntary. Seven residents were using bedrails as enablers. Assessments and consents were in place. Restraint has been discussed as part of the RN/ clinical meetings. Staff receive training around restraint minimisation and challenging behaviours.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint policy states restraint evaluations are to include the areas identified in 2.2.4.1 (a) – (k). Two residents with enablers were reviewed. Both enablers had been reviewed as part of care plan review six monthly. The RN team are the restraint committee responsible for restraint and enabler use review and evaluation. The previous finding has been addressed. Restraint use is documented as discussed in key meetings. The previous finding has been addressed.</p>

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The five long-term resident files reviewed (including the residents not on the ARRC) had interRAI assessments completed within timeframes and the previous finding has been addressed. Interim (initial) care plans were completed within timeframes and the previous finding has been addressed, however, long-term care plans were not always reviewed within expected timeframes. The respite resident had an interim care plan in place (link 1.3.6.1).</p>	<p>One rest home and one hospital care plan reviewed were not completed within six months.</p>	<p>Ensure all care plans are reviewed/evaluated within expected timeframes as per policy.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and</p>	<p>PA Low</p>	<p>Care plan interventions were documented in the electronic care plans to guide staff; however, care plan interventions did not always reflect documentation in monitoring charts or progress notes. Neurological observations were initially recorded for unwitnessed falls with potential for a head injury, however, these were not always recorded according to policy.</p>	<p>(i) Six of nine (one hospital and five rest home) incident reports reviewed for unwitnessed falls with potential for a head injury did not have neurological observations recorded as</p>	<p>(i) Ensure neurological observations are completed as per policy for all unwitnessed falls with potential head injuries.</p>

desired outcomes.			<p>per policy.</p> <p>(ii). One rest home level resident did not have current interventions documented around weight loss and a current wound,</p> <p>(iii). One hospital care plan did not include interventions reflective of the progress notes and GP consultation notes around palliative care needs.</p>	<p>(ii) – (iii) Ensure care plan interventions reflect current needs.</p> <p>180 days</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.