Glenbrae Resthome and Hospital Limited - Glenbrae Resthome and Hospital

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:	Glenbrae Resthome and Hospital Limited
Premises audited:	Glenbrae Resthome and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 March 2021 End date: 16 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: 41

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 Glenbrae is part of the Arvida aged care residential group. The service provides rest home and hospital (medical and geriatric) level of care for up to 41 residents in the care centre and up to 15 residents in the serviced apartments. On the day of the audit there were 41 residents including two rest home residents in serviced apartments. The service is managed by an experienced village manager/registered nurse who has been in the role 10 years. She is supported by a clinical manager and clinical coordinator, national quality manager and stable workforce.

The residents, relatives and allied health professionals interviewed spoke positively about the care and services provided at Glenbrae.

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, interviews with residents, family, management and staff.

There was one area identified for improvement around interventions.

The service has continued to maintain a continued improvement rating around the food service.

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.

Open disclosure is practiced. Relatives are kept informed on their relative's health status and notified promptly of any concerns. There are resident and relative meetings and newsletters. There is the opportunity to provide feedback on the service through annual surveys. Discussions with residents and relatives confirmed that residents and (where appropriate) their families are involved in care decisions.

There is an established system for the management of complaints, which meets timeframes established by HDC.

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.

Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, clinical manager and clinical coordinator oversee and manage day-to-day operations. Goals are documented for the service with evidence of regular reviews.

A quality and risk management programme are in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week and on call 24/7. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

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 low risk.

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. Electronic care plans and records reviewed 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. Qualified nurses and senior 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 Wellness Leaders 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.

The building holds a current warrant of fitness. There is a reactive and planned maintenance programme in place. Residents can freely mobilise within the communal areas with safe access to the outdoors, 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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents requiring the use of restraint and two residents using an enabler. Staff regularly receive education and training in restraint minimisation and managing 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.

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. The infection control coordinators collate results of surveillance which are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks. Additional education and resources were provided during Covid-19 restrictions.

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	1	14	0	1	0	0	0
Criteria	1	39	0	1	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints procedure, and the complaints process is explained in the service information provided to all residents and families. The complaints/compliments procedure/forms and advocacy brochures are available at the main entrance. A record of all complaints, both verbal and written is maintained by the village manager using a complaints' register. There was one complaint made in 2019 and four complaints for 2020 with none to date for 2021. Complaints reviewed were managed in accordance with Right 10 of the Code. A review of complaint documentation evidenced investigations, letters of response and resolution of complaints to the satisfaction of the complainants. Residents and family members advised that they are aware of the complaint procedure. Family members stated that the service is very responsive to concerns and manages them quickly and efficiently. Discussions around concerns, complaints and compliments were evident in facility meeting minutes.
Standard 1.1.9: Communication Service providers communicate	FA	There is a policy to guide staff on the process around open disclosure. The village manager and clinical nurse manager (interviewed) operate an open-door policy. They confirmed family are kept informed on facility matters and their relative's health status. Two relatives of hospital level residents (interviewed) stated that they were notified promptly of any incidents/accidents and are invited to the six-monthly multi-disciplinary meetings. There are monthly resident meetings and also family wellness meetings. There are monthly newsletters sent out to relatives.

effectively with consumers and provide an environment conducive to effective communication.		There is documented evidence that families and residents were kept well informed on Covid-19 restrictions and protocols. Residents/relatives have the opportunity to feedback on service delivery through surveys. The February 2021 surveys results were displayed (sighted) on the facility notice board near the main entrance. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Glenbrae Home and Hospital is owned and operated by the Arvida group. The service provides rest home and hospital – geriatric/medical level care for up to 41 residents in the care centre and rest home care for up to 15 residents in the serviced apartments. All 41 beds in the care centre are certified as dual-purpose beds. On the day of the audit, there were 14 rest home level residents and 27 hospital level residents. This included two (rest home level) residents in the serviced apartments, and two short-term residents (one rest home and one hospital) under ACC funding (one under an intermediate DHB ACC contract). All remaining residents were under the age-related residential care services agreement (ARCC). The Arvida organisation has an overall strategic business plan that includes a mission, vision and values. Glenbrae has a site-specific business plan/goals that align with the Living Well framework. The service business plan was reviewed in February 2021 and lists goals around the resident experience, health and safety, infection control, leadership and occupancy. Achievements against these plans are regularly reviewed by the management team. Regular meetings are held between the village manager and head office. There are monthly zoom meetings with the national quality manager. The village manager is a registered nurse and maintains an annual practicing certificate. She has been in this role at the facility for 10 years. The village manager is supported by a clinical manager (RN) and a clinical coordinator. The village manager has completed eight hours of professional development in the past twelve months including attending a Leadership conference. During Covid-19 restrictions the village manager attended weekly zoom meetings held by a virologist contracted by Arvida to provide education and training.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established,	FA	The service has a quality risk management programme that is monitored by support office personnel and the national quality manager. Arvida Group policies are reviewed at least every two years across the group and are available to all staff on the intranet. The policies and procedures are implemented and provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff interviewed (clinical coordinator, three wellness partners/caregivers and two wellness leaders) confirmed they are informed of new/reviewed policies.

documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		Monthly staff/quality meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. This meeting collates all matters arising from all other facility meetings and committee meetings to ensure an overall quality approach. The service collates accident/incident and infection control data. Monthly comparisons include trend analysis and graphs which are available to staff. Additional meetings include monthly RN/enrolled nurse meetings (where clinical issues are discussed), activity and family/resident wellness meetings. The staff interviewed were aware of quality data results, trends and corrective actions. Benchmarking occurs within the organisation. There is a robust internal audit programme that covers all aspects of the service including environmental, clinical, infection control, health and safety and support services. Re-audits are completed if required and corrective actions are developed, implemented and signed off. There is an implemented health and safety and risk management system in place including policies to guide practice as well as a health and safety committee meeting that follows on from the monthly staff meetings. Staff confirmed they are kept informed on health and safety matters at meetings. The business plan includes a health and safety goal to reduce staff injury lost time at work by 10%. There is a current hazard register which is reviewed regularly. Health and safety representatives have completed on-line health and safety courses. The service has documented emergency plans covering all types of emergency situations and staff receive ongoing training around this. Falls management strategies include assessments after falls and individualised strategies for falls prevention.
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 village manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly quality meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents following an incident/accident. Seven incident forms reviewed on the electronic management system demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observations had been completed for residents with potential or obvious head injury. 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 four Section 31 notifications since the last audit including RN shortage (August 2019), absconding involving police (February 2020), stage 3 pressure injury (January 2021) and resident aggression (February 2021).

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 requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A record of practising certificates for RNs, ENs, GPs and other allied health professionals is maintained. Five staff files were reviewed (clinical coordinator, one RN, one EN, one wellness partner/caregiver and one wellness leader) evidenced that employment agreements and job descriptions were signed, and reference checks were completed. Annual performance appraisals had been completed. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice and is specific to work type. The in-service education programme is complemented by a computer-based learning programme that staff can utilise if they are unable to attend an in-service. The service has an enrolled nurse learning educator who includes orientation into her role. Staff complete Altura on-line sessions which cover the mandatory requirements. Due to Covid restrictions external speakers have been unable to complete training. The physiotherapist provides repeat sessions for safe manual handling competencies. Staff have the opportunity to complete Careerforce units with an external assessor. Staff complete competencies relevant to their role such as medications and hoist training. There are 12 RNs. Eleven have completed interRAI training with one RN in training. Registered nurses have the opportunity to attend external training, including sessions provided by the local DHB.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Glenbrae Home and Hospital's policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. In addition to the village manager (RN with current practicing certificate), who works full time, there is a clinical manager/RN and a clinical coordinator/RN who work Monday to Friday. Two RNs are rostered on the AM shifts for Monday to Thursday and one for Friday to Sunday. There is one RN on PM and night shifts. There is an enrolled nurse on duty Monday to Friday morning shifts. The care facility is divided into four dual-purpose wings. Wellness partner/caregiver staffing rosters are as follows: Rosewood and Glengary wings (11 hospital level residents and seven rest home level residents): two caregivers on full shifts plus one medication competent caregiver 7 am-12.30 pm. There are two caregivers on the afternoon shift with one finishing at 9.30 pm. There is a medication competent caregiver from 4.30 pm-7.30 pm. Jasmine wing (11 hospital and two rest home level residents): two caregivers on morning shift with one finishing at 2.30 pm and two caregivers on full afternoon shifts between Jasmine and Camilla households. Camilla wing (five hospital and three rest home level residents): one caregiver from 7 am-1.30 pm and assistance on the PM shift by the caregivers rostered for Rosewood, Glengary and Jasmine wings. There are two (flexi) caregivers rostered in the AM shift (7 am-11.30 am and 7 am-12.30 pm. There are three flexi

		caregivers on the afternoon shift (4 pm-7 pm, 4 pm-8 pm and 4 pm-7.30 pm). Short shifts and flexi shifts can be extended to meet an increase in resident acuity. There two caregivers on night shift with one being allocated to the serviced apartments as required. There are two home assistants on duty from 7.30 am-10.30 am who assist with bedmaking and morning teas. There is a home assistant from 6 pm-9 pm. The serviced apartments (two rest home level) have a one full shift caregiver and one short shift caregiver. There is a home assistant on the night shift. The night shift is covered by the care centre staff. There are separate cleaning and laundry staff rostered seven days a week. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.
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. Clinical staff who administer medications (RNs, enrolled nurses and wellness partners/senior caregivers) have been assessed for competency on an annual basis and complete Altura medication education. Registered nurses have completed syringe driver competency. Medications are stored safely in the care centre and serviced apartments. All medication (robotic rolls) is checked on delivery against the medication chart and reconciliation is entered into the electronic medication system. There were no residents self-medicating. The medication fridge is checked daily and are maintained within the acceptable temperature range. There is an air conditioning unit set at below 25 degrees. Daily recordings are maintained. All eye drops sighted in the medication trolleys were dated on opening. There is a bulk supply order for hospital level residents and the expiry dates are checked regularly. Ten medication charts (electronic) 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 indications for use and the effectiveness documented in the electronic medication system.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this	CI	All meals and baking are prepared and cooked on site by two cooks who cover the seven-day week. The cooks are supported by morning and afternoon kitchenhands. The food services staff have completed food safety training. Each household has a household assistant from 7 am to 9.30 am. Buffet breakfasts are provided, and the menu provides options. There are six-weekly rotating seasonal menus that have been reviewed by the dietitian. The chef receives dietary forms for each resident and is notified of any changes to dietary needs or weight loss. Dislikes are known, and alternative foods are offered. The menu provides pureed/soft meals. The kitchen is adjacent to the main dining room and meals are plated in the kitchen and served to residents in the dining room. Meals are plated, covered and delivered on a trolley to the second dining room and resident rooms. Meals are delivered in the bain

service is a component of service delivery.		marie to the serviced apartments. Freezer, fridge and end-cooked, re-heating (as required), cooling and serving temperatures are taken and recorded daily. The dishwasher rinse and wash temperatures are taken and recorded. Temperatures of inward chilled goods is recorded. 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. The current food control plan expires 14 December 2021. Residents provide feedback on the meals through resident meetings and resident survey. The cook receives feedback directly, both verbally and through resident meetings. Residents and relatives interviewed spoke positively about the choices and meals provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Not all identified risks had documented interventions or monitoring charts in place. Three of four long-term care plans reflected the outcomes of the interRAI assessment. Wellness partners/caregivers and RNs sign a care activity worklog with scheduled tasks and monitoring charts including repositioning, bowel chart, behaviour chart, food and fluid chart, weight, neurological observations and pain monitoring. Not all monitoring requirements had been implemented. Family is notified of all changes to health as evidenced in the electronic progress notes. The GP completes three monthly resident reviews or earlier for any changes to a resident's health status. Wound assessments, wound management plans with body maps, photos and wound measurements were reviewed on eCase for 10 residents with wounds (11 skin tears, one venous ulcer and three pressure injuries). There were two stage 2 pressure injuries and one community acquired stage 3 pressure injury (Section 31 sighted). The wound champion (RN) reviews wounds weekly and has access to the DHB wound nurse as required. There was adequate pressure injury equipment including air alternating mattresses, pressure relieving cushions and gel heel pads. Staff had completed education on skin integrity and prevention of pressure injuries. The clinical manager and wellness manager have been invited to join the DHB Lakes Clinical nurse educator who is initiating a project around best approach to pressure injury prevention for ARC providers. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. There is access to a continence specialist as required.
Standard 1.3.7: Planned Activities Where specified as	FA	The service employs a team of Wellness Partners who cover the Monday to Friday integrated rest home/hospital programme within the households. The recreational programme incorporates the Arvida living well model – engaging well, thinking well, moving well, resting well, and eating well.

part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		Wellness partners/caregivers are involved in activities within their household and assist residents to attend activities in the main lounge. Rest home level of care residents in studio apartments may choose to join in the care centre activities. Wellness partners/caregivers coordinate activities in the weekends. There are plenty of resources and an exercise trolley set up. Two wellness leaders are also physiotherapy assistants and take daily exercise groups. There are regular walks and a walking group. The programme meets the cognitive and physical abilities and preferences of the residents and includes news chat, quizzes, music, arts and crafts, table tennis, discussion groups, board games, happy hours and one-on-one time. Volunteers are involved in assisting with the activities. There are cultural days and armchair travel. Entertainers and community visitors such as kindergarten children and pet therapy visit regularly. Special events and festive occasions are celebrated. There are regular outings and scenic drives. A mobility van is hired for hospital level resident outings. A resident leisure profile 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.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes for the long-term resident files reviewed. Family is invited to attend the multidisciplinary review meeting and case conference notes are kept. Written 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. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes.
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 18 February 2022. The maintenance officer works four days a week. There are maintenance forms and a box at the main entrance which is checked daily and signed off when repairs have been completed. There is a monthly planned maintenance schedule which includes electrical testing and tagging, resident equipment checks, call bell checks and calibrations such as hoists and weigh scales. Essential contractors/tradespeople are available 24 hours as required. Monthly hot water tests are completed for resident areas. There is a gardening team employed to maintain the gardens and grounds. Studio apartments and care centre resident rooms are refurbished as they become vacant. There are plans to refurbish the entrance way. The corridors are wide and promote safe mobility with the use of mobility aids. Residents were observed moving

		freely around the areas with mobility aids where required. The external areas, courtyard and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents. Bariatric equipment is available through the organisation.
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 signs, symptoms and definition of infection. Infections are entered into the infection register on the electronic database. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. The infection control coordinator (RN) collects and collates data which is monitored and analysed for trends monthly and annually. Infection control surveillance is discussed at the monthly infection control committee meetings (following the RN meetings) and have a representative from each service area. Infection control is an agenda topic at clinical and facility meetings. Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives benchmarking feedback from the support office. There have been no outbreaks. Zoom meetings were held between the Infection Control nurse and the management team regarding Covid-19 updates, protocols and resources. There is a new DHB initiative for post Covid facility visits that include training/education and ensuring the facility has adequate personal protective equipment in the event of an outbreak.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has implemented systems to ensure the use of restraint is actively minimised. A registered nurse/clinical coordinator is the designated restraint coordinator. There were no residents with restraint and two (hospital level) residents who had voluntarily requested an enabler (safety device lap belts). Both enabler files were reviewed, and all necessary documentation has been completed in relation to the enablers. Consent had been voluntarily obtained. Restraint/enablers are discussed at clinical, health and safety and quality meetings. Staff complete Altura training and safe manual handling sessions.

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)
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	The outcomes of interRAI assessments were linked to three of four long-term care plans with appropriate interventions documented. Interventions and monitoring charts had not been implemented for one short-stay intermediate care resident under ACC funding.	(i) The initial assessment/interim care plan for the short-stay intermediate care resident under ACC identified a risk of pressure injury due to being non-weight bearing with a plaster cast on one leg. There were no documented interventions for the prevention of pressure injuries and no monitoring charts in place to check the colour, warmth, movement and sensation of the affected limb and (ii) there was no cardiorespiratory monitoring as identified and triggered in the interRAI assessment for one rest home long-term resident.	(i) Ensure identified short-term needs are monitored and reported, and (ii) ensure outcomes identified from interRAI assessments are monitored. 90 days

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 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer	CI	The February 2021 survey results for food services, while above the overall average Arvida rate, identified there could be an improvement around the dining experience. The service has achieved 100% silver level and working towards the gold level of the eating well pillar of Avida’s living well model.	A quality improvement plan was developed to improve the dining experience for residents which included; training for staff on presentation and alternative choices, chef one-on-one time with residents, menus on the tables, new table cloths and placements, smaller dining areas to encourage relationships, cooked breakfasts weekly, inclusion of client choice/baking choice into the menu and wine with meals. There has been a review of additional staffing hours for fresh baking and introduction of pure foods and AdVital fortified nutritional supplements. An alternative fluid thickener of better quality was sourced that mixed more easily for all fluids. The chef attends resident meetings and also receives feedback on meals from the food note book in the studio apartments and positive dining survey forms (box available in reception). Resident meeting minutes and verbal feedback from residents and relatives interviewed demonstrated the service has continued to improve the dining experience and meals provided.

group.			

End of the report.