

Lady Wigram Limited - Lady Wigram Village

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 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:	Lady Wigram Limited
Premises audited:	Lady Wigram Village
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 14 September 2021 End date: 15 September 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:	68

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

Lady Wigram Village provides rest home, hospital and dementia level care for up to 140 residents in the care facility. On the day of audit there were 68 residents in total. The service is privately owned, purpose-built and opened November 2021.

This certification audit was conducted against the relevant Health and Disability 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, relatives, management, staff and the general practitioner.

Lady Wigram Village has an organisational total quality management plan and key operations quality initiatives documented. Quality objectives and initiatives are set annually and in progress.

The general manager (background in aged care and Human Resource management) is supported by a care facility manager (RN). The management team includes a part-time quality manager.

This certification audit identified areas for improvement including hazard identification, staff orientation, care planning and interventions, monitoring and physical environment.

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 and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. There is an established system for the management of complaints.

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.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated and are appropriate to the needs of the residents. A care facility manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive appropriate services from suitably qualified staff. Human

resources are managed in accordance with good employment practice. Ongoing education and training is in place, which includes in-service education and competency assessments. Registered nursing cover is provided twenty-four hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is an admission package available prior to or on entry to the service. 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 input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

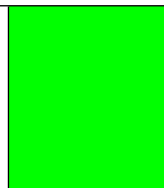
Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities team implements the activity programme in each unit to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

All meals and baking are done on site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

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.



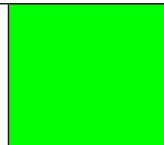
Standards applicable to this service fully attained.

The building has a current compliance certificate. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy with an ensuite. There are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on site.

There is an approved fire evacuation scheme. There are six-monthly fire drills. Staff have attended emergency and disaster management training.

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.

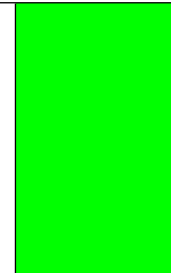


Standards applicable to this service fully attained.

Restraint minimisation is practiced and overseen by the clinical manager. There were no residents using enablers or restraints. Staff receive training around restraint minimisation and management of challenging behaviour.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (a registered nurse) is responsible for coordinating/providing education and training for staff. The quality team supports the infection control coordinator. Infection control training has been provided within the last year with additional sessions relating to Covid-19. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other facilities.

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	41	0	3	1	0	0
Criteria	0	89	0	3	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Lady Wigram Village policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Three managers (one care facility manager, one clinical manager and one general manager) and fifteen care staff; including four registered nurses (RNs), eleven caregivers (four dementia, four hospital and three rest home) and four activities staff (two diversional therapist and two activities assistants) described how the Code is incorporated into their working environment. Staff receive training about the Code during their induction to the service (link 1.2.7.4). This training continues through the mandatory staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the nine resident files reviewed (three hospital, three rest home level, and three dementia level care). Caregivers and registered nurses interviewed confirmed consent is obtained when delivering cares. All advance directives had been appropriately signed by the resident and general practitioner (GP). Advance directives also identified the resident resuscitation status.</p> <p>The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The GP had discussed resuscitation with families/enduring power of attorney (EPOA) where</p>

informed consent.		the resident was deemed incompetent to make a decision. Discussion with residents' family members identified that the service actively involves them in decisions that affect their relative's lives. Nine admission agreements were sighted for the resident files reviewed. The three dementia files reviewed had activated EPOA on file.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on the resident's family/whānau and chosen social networks.
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 and relatives interviewed confirmed open visiting and were also aware of restricted visiting policies during Covid-19 lockdown levels. Visitors were observed coming and going during the audit on appointment basis during level 2. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisational complaints policy is being implemented at Lady Wigram Village. The care facility manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The clinical manager is involved in clinical complaints. The facility has an up-to-date complaint register for each unit. Concerns and complaints are discussed at relevant meetings. There have been three complaints made in 2021 (related to the environment) and none received in 2020 since the opening of the care facility in November 2020. Complaints have been acknowledged and addressed within the required timeframes.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Nine relatives (two rest home, two hospital and five dementia care) and six residents (five rest home and one hospital care) stated they were provided with information on admission which included the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The care facility manager reported having an open-door policy and described discussing the information pack with residents/relatives on

		admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Lady Wigram Village has policies that support resident privacy and confidentiality. A tour of the facility confirmed there all areas support personal privacy for residents. During the audit, staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms and ensuring doors were closed while cares were being done. The service has a philosophy that promotes quality of life, independence, choice and involves residents in decisions about their care. Residents' preferences are identified during the admission and care planning process with family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers interviewed described how choice is incorporated into resident cares. Staff attend education and training on abuse and neglect, last completed in April 2021.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>Lady Wigram Village has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The service has links with the local district health board (DHB) for advice and support as required. There were two residents (one hospital and one rest home) who identified as Māori at the time of the audit, however cultural needs for one resident were not addressed in the resident's care plan (link 1.3.5.2).</p> <p>Staff completed training in cultural awareness as part of their orientation to the service and annually (June 2021). Care staff interviewed confirmed they are knowledgeable around Māori needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p>	FA	<p>Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>and mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Lady Wigram Village have a current master copy of policies and available electronically to all staff, which have been developed in line with current accepted best practice and these are reviewed and updated by an external consultant. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have a self-learning package for staff, which are based on their policies. A range of clinical indicator data are collected against each service level for collating, monitoring and comparison purposes.</p> <p>Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used to report relevant data. The system of data analysis and trend reporting is designed to inform staff at the facility level in real time. Management at facility level are then able to implement changes to practice based on the evidence provided.</p> <p>There are various roles (champions) established to assist with the process of embedding policies and procedures and include a staff trainer, fall prevention coordinator, medication and pain coordinator, interRAI coordinator, wound and weight coordinator.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an incident reporting policy that guides staff to their responsibility to notify family of any resident accident/incident that occurs. Fourteen incident forms reviewed evidenced the family had been informed of the accident/incident. Relatives interviewed, stated that they are informed when their family members health status changes. Six monthly relative meetings occur in each of the units (rest home, hospital and dementia care). Residents interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. Specific introduction information is available on the dementia unit for family, friends and visitors to the unit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter policy and contact details of interpreters is available.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of</p>	<p>FA</p>	<p>Lady Wigram Village is located in Christchurch and is part of a wider village. The facility is a new purpose-built facility that opened November 2020. The service provides care for up to 140 residents at hospital, rest home and dementia level care.</p> <p>On the day of audit there were 68 residents in total.</p>

<p>consumers.</p>		<p>The rest home unit (all dual-purpose) has 40 beds with 26 beds occupied, including one private resident not on an aged residential care service agreement and one on respite care. There are two hospital wings (all dual-purpose): Pod A has 23 beds with 17 occupied including two respite care residents, one on an end-of-life contract and two rest home residents and Pod B and C has 37 beds which is unoccupied as they are still in the process of being furnished. There are two secure dementia units: Corsair unit has 20 beds with 13 occupied and Skyhawk unit has 20 beds with 12 occupied (including a respite care).</p> <p>Lady Wigram Village has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and initiatives are set annually. The organisation-wide objectives are documented for Lady Wigram Village and include business objectives. Progress towards objectives are updated as the service increases in occupancy.</p> <p>The care facility manager at Lady Wigram Village is a registered nurse and has been in the role since January 2021. She is supported by a general manager/owner (non- clinical) who has been in the role for 11 months (she worked previously at an operational manager in aged care) and a clinical manager, who has been in the role for 11 months (seven years as RN). The care facility manager is also supported by a part time quality lead (not in attendance on audit days or interviewed), care facility administrator and finance manager.</p> <p>The care facility manager and general manager have maintained over eight hours annually of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>The clinical manager is responsible during the temporary absence of the care facility manager, with support from the general manager/owner.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>PA Low</p>	<p>Lady Wigram Village service have a documented quality and risk management programme. Quality and risk performance is reported across the facility meetings (full facility, clinical, health and safety/infection control meetings) and reported to the organisation's management team. Discussions with the management team (care facility manager, general manager/owner and clinical manager) and staff, and review of meeting minutes demonstrated their involvement in quality and risk activities. The</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>first annual resident and relative surveys are planned for October 2021.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery. Management systems are being implemented and reviewed including an internal audit programme. Quality improvement plans are implemented for audit outcomes less than 90%. Re-audits are completed as required. The facility has implemented processes to collect, analyse and evaluate data including infection control, accidents/incidents, complaints which are utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the combined monthly health and safety and infection control meetings. The health and safety officer (property manager) was interviewed. He has completed level one external health and safety training. Health and safety meetings are conducted bi-monthly. Risk management, hazard control and emergency policies and procedures are in place. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The hazard register was reviewed in June 2021. The hazard identification process identifies any new hazards, however the recent hazard related to the fire doors (residents absconding from the secure dementia unit) was not entered in the hazard register.</p> <p>Falls prevention strategies are in place that include ongoing falls assessment, reviewing call bell response times and routine checks of all residents specific to each resident's needs. All falls are fully investigated, medical causes identified and treated, location and timing of falls analysed for trends and ongoing education includes manual handling, hoist refreshers, intentional rounding and use of equipment such as sensor mats, physiotherapy input and encouragement in exercise programmes. Case studies are discussed at clinical meetings. General practitioners are notified of falls and a medical review including medication review is completed. Care plans record falls prevention strategies that reflect the residents falls risk. Falls prevention and management training has recently been held at a full facility meeting in April 2021 for all staff to attend.</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</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of 14 incident/accident forms for August 2021 from across all areas of the service, identified they all were fully completed, including follow-up by a registered nurse (RN) and relative notification. Post falls assessments included neurological observations for six</p>

<p>consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>unwitnessed falls with potential head injuries. The clinical manager is involved in the adverse event process, with links to the applicable meetings (full facility, clinical, health and safety/infection control). This provides the opportunity to review any incidents as they occur.</p> <p>The care facility manager and clinical manager were able to identify situations that would be reported to statutory authorities. A total of 21 incidences have been reported under section 31. There has been thirteen (January - end May 2021) section 31 notifications made for wandering (not missing or absconding from the building) of dementia residents within the building (when the dementia unit was temporary on the first floor), three incidences of absconding from the secure unit through a fire door (all residents were found inside the building) within the first few days when the dementia unit moved to the ground floor (between 25 June and 1 July 2021); two in July 2021 including a stage three pressure injury and one missing (rest home resident) also three post-fall fractures reported (one in May, August and September 2021).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one clinical manager, three RNs, three caregivers, health and safety officer and one head chef) provided evidence of signed contracts, job descriptions relevant to the role and reference checks. Evidence of induction and 90-day performance review were not always completed as per the policy. A register of RN and health professional practising certificates are maintained and current. An orientation/induction programme provides new staff with relevant information for safe work practice. There is an annual education plan for 2021 being implemented. The annual training programme exceeds eight hours annually. Additional toolbox sessions and online education are provided through an online care training provider.</p> <p>Registered nurses are supported to maintain their professional competency. The management team, activities persons, RNs and twelve caregivers hold a current first aid certificate. There are implemented competencies for RNs and caregivers related to specialised procedures or treatments including medication competencies, insulin competencies and wound care competencies; however, syringe driver competencies for five of the registered nurses have not yet been scheduled or completed. There are arrangements in place with the community palliative nurse and local hospice to assist when this is required. Education sessions have been completed for medication management, palliative care and Te Ara Whakapiri implementation. On the day of the audit the care facility manager arranged dates for syringe driver education and competency for the five RNs.</p> <p>Caregivers are encouraged to gain qualifications with the New Zealand Qualification Authority (NZQA). There are twenty caregivers with either level 3 or 4 Careerforce qualifications.</p> <p>There are seven RNs working at Lady Wigram Village and five RNs have completed interRAI training. Twelve caregivers work in the dementia unit, six caregivers have completed their dementia standards</p>

		and six are enrolled.
<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>	FA	<p>Lady Wigram Village organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. There is casual staff to cover unplanned absences. A plan of action document is available for staff around any weekly staff changes. The care facility manager, clinical manager and general manager work Monday to Friday and the quality lead works three days a week. The care facility manager and clinical manager is on call 24/7 for any operational and clinical issues respectively. They are supported by a RN in the rest home, hospital and dementia unit.</p> <p>The rest home unit has 40 beds with 26 beds occupied, including one private resident not on an aged residential care service agreement and one on respite care. The roster is as follows:</p> <p>Morning shift - RN (Monday - Thursday) 7 am-3.30 pm and supported daily by caregivers (7 am-3 pm) x3.</p> <p>Afternoon shift: caregivers (3 pm-11 pm) x2; caregiver (3 pm-11.15 pm) x1.</p> <p>Night: caregiver (11 pm-7.15 am) x2.</p> <p>Activities assistant: Monday to Thursday 7 am - 3.30 pm, DT Tuesday to Saturday 8.30 am- 5 pm and physiotherapy assistant Monday, Tuesday, Thursday and Friday 8.30 am-5 pm.</p> <p>There are two hospital wings: Pod A has 23 beds with 17 occupied including two respite care residents, one on an end-of-life contract and two rest home residents and Pod B and C is not currently occupied. The roster is as follows:</p> <p>RN (Monday- Sunday) 7 am-3.30 pm and second RN (Tuesday, Wednesday, Friday) 7 am-3.30 pm supported daily by:</p> <p>Morning shift: caregivers (7 am-3.15 pm) x3 and an extra full-time caregiver will be included in the roster when occupancy reaches 20 occupied beds (a fourth caregiver allocated Tuesday and Wednesday 7 am - 3.15 pm).</p> <p>Afternoon shift: RN (Monday-Sunday) 3 pm-11 pm supported by caregivers (3 pm-11.15 pm) x3; and extra fourth full time caregiver (3 pm-11.15 pm)</p> <p>Night: RN (Monday-Sunday) 3 pm-11 pm supported by caregiver (11 pm-7.15 am) x2</p> <p>Activities assistant: Monday to Thursday 8 am-4.30 pm, DT Tuesday to Saturday 8.30 am- 5 pm</p> <p>The two secure dementia units: Corsair unit has 20 beds, and 13 occupied and Skyhawk unit has 20 beds and 12 are occupied (including a respite care).</p>

		<p>RN (Monday- Sunday) 7 am-3.30 pm oversee both units supported daily by:</p> <p>Corsair unit: Monday- Sunday</p> <p>Morning shift: caregivers (7 am-3.15 pm) x3 (third caregiver is a fluid assistant)</p> <p>Afternoon shift: caregivers (3 pm-11.15 pm) x2</p> <p>Night: caregiver (11 pm-7.15 am) x1</p> <p>For Skyhawk unit: Monday-Sunday</p> <p>Morning shift: caregivers (7 am-3.15 pm) x2</p> <p>Afternoon shift: caregivers (3 pm-11.15 pm) x2</p> <p>Night: caregiver (11 pm-7.15 am) x1</p> <p>DT: Monday to Friday 9 am-5.30 pm</p> <p>The hospital RN covers the rest home and dementia unit on afternoon and night shifts.</p> <p>There are separate laundry and cleaning staff.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Eleven caregivers interviewed (four hospital, four rest home, three dementia care) stated the RNs are supportive and approachable. Interviews with residents and relatives indicated that overall there are sufficient staff to meet resident needs.</p> <p>The service is currently recruiting for a registered nurse, caregiver and housekeeper. There is a planned process for the roster to meet the needs of the residents once Pod B and Pod C opens. The care facility manager confirmed they planned to occupy the first seven beds (Pod B) of 37 from November 2021 and the remaining beds from January 2022 (link 1.4.2.4).</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrated service integration.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Residents are assessed prior to entry to the service by the needs assessment (NASC) team, and an initial assessment with an interRAI assessment completed on admission. Prospective residents are screened by the general manager and clinical manager, with discussions with the nursing team for residents with more complex needs.</p> <p>Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. There is specific information provided for families in the dementia unit. The three dementia residents whose files were sampled had NASC approval for the service. All admission agreements reviewed (for long-term residents) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. A total of nine signed admission agreements were sighted. Family members interviewed stated the management team had fully explained services to them on entry to services.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The RNs, and caregivers interviewed described the documentation and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents as sighted in one residents file who was recently transferred to hospital. These documents are placed in a yellow transfer envelope. Families were fully informed of the transfer process.</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>Medicines management policies and procedures reflect current medication legislation and residential care guidelines. Only registered nurses or senior caregivers who have been assessed as competent are permitted to administer medicines to residents. A register is to be in place to identify staff designated as medication competent staff. These are currently up to date. Medication management and competencies are completed as part of induction and annually. Five registered nurses have not yet completed syringe driver competencies (link 1.2.7).</p> <p>The service uses four weekly blister packs and an electronic medication system. There is a secure treatment room situated between the two dementia units, with secure access from each unit. The rest home and hospital treatment rooms are centrally located and are secure. Medication fridges and treatment room temperatures have been monitored daily and are within expected ranges. There are air ducts into the treatment rooms which cools the room temperatures. All treatment rooms are fully furnished and functioning. A contract with a pharmacy is in place. Standing orders are not used. Regular medication audits occur as scheduled. Schedules are placed in each room with dedicated days of the week to complete tasks including checking drugs for expiry, and cleaning trolleys.</p>

		<p>Eighteen medication charts were reviewed on the online system. All included individual medication charts with photo identification, allergies/adverse reactions were noted, and required medications prescribed correctly with indications for use. There is system used to indicate “duplicate name”. Three monthly reviews by the GP are documented. ‘As required’ sedation/antipsychotic medication administered in the dementia unit, all correlate to progress notes indicating a need. There is a very low usage of ‘as required’ sedation and antipsychotic medications. There were three residents (one rest home and two hospital) self-medicating medications on the days of the audit, self-medication competencies were in lace and have been signed and reviewed by the GP. Medications were stored securely in the residents’ rooms. The drug rounds sighted aligned with current medication guidelines.</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>	FA	<p>There are food service policies and procedures including a verified food control plan. There is one head chef, four cooks and three kitchenhands in in the food services team. All have completed food safety training. All meals and baking are freshly prepared and cooked in the spacious hotel-styled kitchen. There is a servery bay into the rest home dining room from the kitchen. Food is transported in thermal boxes to the kitchenette areas in the hospital and both dementia units. Meals are served from a bain marie from the satellite kitchen.</p> <p>The menu has been designed and reviewed by a registered dietitian in March 2021. A current food control plan is in place expiring in June 2022. The chef maintains a folder of residents’ dietary requirements that include likes/dislikes. The main meal is served at lunchtime with a light meal served at tea-time. Alternatives are offered, and alternatives are provided as needed. Specialised utensils and lip plates are available as required. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternatives offered. Fridge and freezer temperatures are recorded daily for the kitchen appliances. Perishable foods in the chiller and refrigerators are date labelled and stored correctly. The kitchen is clean and has a good workflow. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves. Chemicals are stored safely, and safety datasheets are available. Nutritious snacks are available 24/7 in the dementia units. Snacks are stored in the fridges in the kitchenette.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the potential residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. No entry to the facility has been declined since commissioning of the building. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>

organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The nine resident files sampled included an initial assessment that was undertaken on the day of admission. An interRAI assessment was completed for all seven long term residents within expected timeframes. These assessments were undertaken at least six monthly or as needs change and served as a basis for care planning. The diversional therapists complete an activity assessment. Additional assessments include (but are not limited to); management of behaviour, pain, nutrition and wound care were appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments were reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Resident long-term care plans reviewed on the resident electronic system for were resident focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. The electronic care plans identified a set of goals including managing medical needs/risks, however, not all interventions were documented in the care plan. Short-term care plans are documented for short-term needs and infections. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration.</p> <p>The three dementia care resident files reviewed had 24-hour activity plans with documented behaviours, triggers and activities to distract and de-escalate behaviours. The long-term care included a detailed behaviour management plan.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian and community mental health services for older people. The contracted physiotherapist has completed transfer plans as appropriate. Medical GP notes and allied health professional progress notes were evident in the residents integrated electronic files sampled.</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>	PA Low	<p>When a resident's condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. Monitoring charts are well utilised. Electronic short-term care plans are utilised for changes to health. Family are notified of all changes to health as evidenced in the electronic progress notes and confirmed during interview. Registered nurses were regularly involved in resident daily care and ongoing assessments as identified in the progress notes. A weekly evaluation is completed by the RNs for residents in the rest home unit, and more frequently as per policy in the hospital and dementia units.</p> <p>Wound management policies and procedures are in place. Electronic wound assessments, wound management plans and photos were reviewed. On the day of the audit, there 11 residents with wounds</p>

		<p>including one resident with a stage 3 pressure injury. The wound specialist had been involved as sighted in wound documentation. An incident report and section 31 notification were sighted. Wounds included skin tears, and cancerous lesions. Wound assessments and wound management plans were in place, however, evaluations documented did not consistently document wound progression. Dressing supplies are available, and the treatment rooms were well stocked. All staff reported that there are adequate dressing supplies and adequate continence products. Specialist wound and continence advice is available as needed through the DHB and the wound or continence product representatives. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>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>Monitoring occurs for weight, blood pressure, blood sugar levels, pain, neurological observations, food and fluid charts. These were sighted across the files reviewed. The RN monitors and reviews the monitoring forms daily on the electronic system. Care staff report any changes to the RN.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>FA</p>	<p>There are two diversional therapists and two activities assistants in the activities team. Each resident (in all units) has an activities/life history assessment completed which includes spiritual and cultural preferences (link 1.3.6.1), which forms the base of the activities plan. The activities plans are electronic and are separate to the residents' long term care plans. Assessments identify former routines and hobbies and activities that the resident is familiar with and enjoys. The activity plans allow for individual diversional, motivational and recreational therapy to be identified across a 24-hour period for residents in the dementia units.</p> <p>The monthly activities planners are based around residents' current likes, dislikes and preferences as far as possible. The activities team meet to plan the monthly planner in each unit to discuss celebrating 'theme days' such as blue (prostate day), pink ribbon day, daffodil day, cultural celebrations and Māori week. Copies of the planner are issued to all residents to display in their room, large copies are displayed throughout the units and in the nurses' stations.</p> <p>Rest Home and Hospital units:</p> <p>Until August 2021, there have been combined activities run over six days a week (Monday to Saturday). With the increase of hospital residents, there is now a hospital activities planner also in place (Monday to Friday). There is one activities assistant in the rest home unit and one in the hospital unit. The diversional therapist shares her time between the units. Activities are currently held five days a week in the hospital unit (Monday to Friday from 10.15 am to 5 pm), and over six days in the rest home unit</p>

		<p>(Monday to Saturday from 9.15 am to 4 pm). Residents from the rest home and hospital units often combine activities, and residents from each unit are welcome to join residents from the other unit for activities so residents can choose which activity to attend. Regular activities include (but are by no means limited to); newspaper reading, quiz, trivia, movies, crafts and exercises. Group activities include indoor bowls, walking groups, golf/putting, housie. A knitting group and men's club have recently been developed as occupancy has increased.</p> <p>Dementia unit:</p> <p>One diversional therapist runs activities in both dementia units over five days a week (Monday to Friday from 9.15 am to 5 pm) with the caregivers assisting residents with activities over the weekend. Activities include (but are not limited to); newspaper reading, exercises, singing and walking groups, golf putting, ball, crafts, group games, and pampering sessions. The dementia programme is designed for residents with memory loss. The planner includes activities occurring in both units. During the audit, the residents were sighted enjoying an activity in the library area of the units. The partition between the two dementia unit lounges can be opened for entertainment. There is a large communal lounge in each unit and a further quiet lounge in each unit for individual and/or group activities.</p> <p>There are a range of visitors to the facility including pet therapy, regular entertainers, church services are held regularly, guest speakers and flower arrangers. There are future plans to invite schools and pre-school children to visit the facility.</p> <p>A facility van is available for outings for all residents. There are weekly van outings (as Covid-19 lockdown levels allow). Two staff go on the outings with residents from all of the units (usually five dementia and five from the rest home/hospital units). Outings include an afternoon tea picnic to areas of interest. All activities staff have first aid certificates. Residents and relatives interviewed all commented on the improvement in the activities programme with the increase of activities staff.</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>All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. InterRAI re-assessments have been completed six-monthly in support of reviewing the care plan. The resident on the end-of-life contract had not been in the facility long enough for a care plan review. Long-term care plans have been evaluated by the multidisciplinary team at least six-monthly or earlier for any health changes (link 1.3.5.2). As part of the review and update of the care plans, an evaluation has been completed. Each section of the care plan is evaluated and evidence progression towards meeting goals.</p> <p>The MDT meeting includes a holistic evaluation of care and support including input from allied health and medical staff. 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</p>

		short-term changes to care are noted in the short-term care plans where required. Residents and relatives interviewed, confirmed involvement in the MDT and evaluation of the care plan, relatives confirmed they are updated of changes if they are unable to attend.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. There is evidence of GP discussion with families regarding referrals for treatment and options of care.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	There are policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. Chemical safety training is a component of the compulsory two-yearly training and orientation training. Chemical supplies are kept in a locked sluice with a sanitiser in all units. A closed system is in place for all chemicals. A contracted supplier provides the chemicals, safety datasheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment including gloves, aprons and goggles were readily available to staff.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current building warrant of fitness, expiring 1 February 2022. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. The service employs a maintenance team of two who carry out minor repairs and maintenance. The maintenance man and the property manager are both employed full-time. The property manager is on call for urgent matters over the weekends. Essential contractors are available 24/7 as required. A maintenance book is situated in the nurses' station of each unit and at reception. The maintenance books are checked regularly throughout the day and are signed off as requests are actioned. All electrical and clinical equipment is less than one year old. The maintenance team checks hot water temperatures and undertakes monthly maintenance audits. The corridors, communal areas and resident rooms are carpeted. Vinyl surfaces are in all bathrooms/toilets, dining and kitchenette areas.</p> <p>Corridors throughout the facility are wide and there are handrails in all corridors which promotes safe</p>

		<p>mobility. Residents were observed moving freely around the areas with mobility aids where required. There are two lifts between the floors that are large enough for mobility equipment. Both lifts can be used in event of a fire. The facilities, furnishings, floorings and equipment are designed to minimise harm to residents.</p> <p>There are external areas and gardens, which are easily accessible (including wheelchairs). There is outdoor furniture and seating, and shaded areas. There are adequate storage areas for the hoist, wheelchairs, products and other equipment. The staff interviewed stated that they have all the equipment referred to in care plans to provide care. Smoking is not allowed in the facility or grounds.</p> <p>The secure dementia units each have a large open plan lounge/dining area with a partition between the two units which are opened when there are large group activities or entertainers for residents. The secure garden areas and internal courtyards are freely accessible to residents. Outdoor furniture and seating have been ordered and were due to arrive shortly after the audit. The garden has paths with no dead ends, and areas of interest are being developed.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>Every resident's room in the facility has full ensuite facilities with a disability-friendly shower, toilet and hand basin. There is a large shower room in the hospital unit which is suitable for a shower bed. The use of different coloured toilet seats in the dementia unit makes an easier contrast for residents with dementia.</p> <p>There are communal toilets near the open plan communal lounge and dining room. There are adequate numbers of toilets and showers with access to a hand basin and paper towels for residents and separate toilet areas for staff and visitors. All toilets and bathrooms throughout the facility have sensor lights in place. All ensuite and communal toilet facilities throughout the facility have paper towels and free flowing soap in place.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents' rooms in all units are single, spacious, and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. All rooms in the hospital have ceiling hoists. In the dementia units, each resident room has a different colour door to assist residents with locating their room. Residents are encouraged to personalise their rooms and the rooms are large enough for family and friends to socialise with the resident.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation,</p>	FA	<p>Each unit has a large open-plan dining area that connects to a large communal lounge area. The library is situated in the rest home. There are two whānau rooms in the hospital unit. The hospital unit</p>

<p>And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>has another small lounge located at the end of a corridor. The lounge areas in the hospital and rest home areas have large fireplaces with furniture arranged around these to create a homely environment. The dementia units have smaller lounge areas and a sensory room in addition to the large open plan communal areas. The open-plan living area and hallways are spacious and allow maximum freedom of movement while promoting the safety of residents who are likely to wander. The communal areas in the dementia units can be opened up when there are large group activities arranged.</p> <p>All external flower garden areas are established and well maintained. There are balcony areas the hospital level residents can enjoy, and loft access to the ground floor. The dementia unit external area is secure, with outdoor furniture due to arrive in the near future. The residents and relatives interviewed were complimentary of the communal areas and décor of the facility.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are policies and procedures in place around housekeeping and laundry processes. There are dedicated housekeeping and laundry staff who provide services across seven days a week. Documented systems are implemented for monitoring the effectiveness and compliance with the service policies and procedures.</p> <p>The laundry has separate entrances for dirty and clean laundry. The laundry is spacious and is the service area to complete personals and towels only. All other laundry is outsourced three times a week. Linen is transported to the laundry in covered linen trolleys with colour coded linen bags. Chemicals are stored securely, and data sheets are located in a visible easily accessible location.</p> <p>Cleaners' trolleys are stored in locked cupboards when not in use. The laundry assistants and housekeeper interviewed were knowledgeable around infection control practices, and the use of chemicals. The cleaning room viewed had a closed chemical system with data sheets available in the room.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is a disaster management plan and emergency evacuation procedure. Emergencies, first aid and CPR are included in the mandatory in-services programme every two years and the annual training plan includes emergency training. Orientation includes emergency preparedness. There are sufficient employed staff with a current first aid certificate to cover all shifts.</p> <p>The service has alternative power systems in place and can hire a generator if needed. There are civil defence kits available in each unit. Drinkable water is stored in several large holding tanks.</p> <p>The "Austco Monitoring programme" call bell system is available in each resident room. There are call bells and emergency bells in communal areas. There is a nurse presence bell when a nurse/carer is in the resident room; a green light shows staff outside that a colleague is in a particular room. The system</p>

		<p>software is monitored. All call bells are functional and tested as part of the monthly preventative maintenance plan.</p> <p>The fire evacuation plan for the whole facility has been approved by the fire service (11 December 2020). Fire training/drill was last completed 11 May 2021.</p> <p>The doors of the village automatically lock down at 6 pm to 7 am with keypad access after-hours. There are documented security procedures and CTV cameras at the entrance, and hallways. The dementia unit on the ground floor is secure with swipe card access. Previous issues related to residents from the dementia unit absconding through fire doors have been resolved (link 1.2.3.9). The dementia units on the ground floor are secure. There is a secure keypad door to the courtyards within the dementia units that can be overridden so they have free access during the day and automatically lock at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There is air-conditioning and heating in common areas and resident bedrooms. These can be individually controlled. Each room has an external window with plenty of natural light. Residents and relatives interviewed stated the facility was maintained and a comfortable temperature.</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>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection control and prevention officer is a registered nurse based in the hospital. There was no job description to define the role and responsibilities for infection control (link 1.2.7.4). The infection prevention and control committee are combined with the health and safety committee, which meets two-monthly. The programme is set out annually and directed via the quality programme. The programme is reviewed annually; however a review was completed by the Quality Lead in June 2021, six months after commissioning of the care facility.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. Hand sanitisers are placed appropriately within the facility. There is a cleaning process in place to manage cleaning of touch screen equipment, medical equipment and hoist slings.</p> <p>Staff were observed to practice good handwashing techniques.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection prevention and control committee (combined with the health and safety committee) meet two-monthly. The infection control coordinator is supported by the quality lead to collate infection rates and provide reports to the committee, management, clinical and facility meetings including trends and analysis of infections. The infection and prevention officers have access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory and expertise from within the organisation.</p> <p>Lady Wigram Village Covid-19 strategies have been implemented within the facility. There are robust processes documented, with training to ensure staff awareness is always up to date. There are plentiful supplies of PPE.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Lady Wigram Village and the policies have been referenced to policies developed by an external consultant. Infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control officer is responsible for coordinating/providing education and training to all staff, and she has attended external training for her role. The orientation/induction package includes specific training around hand hygiene, standard precautions, and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits, proper use of PPE and education annually. Infection control is an agenda item on the full facility and clinical meeting agenda. There is regular toolbox meetings to ensure staff are fully aware of protocols should an outbreak occur.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed on the electronic system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control and prevention officer completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the facility meeting and graphs are displayed.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility.</p> <p>There was one confirmed respiratory outbreak in August 2021, reported to Public Health; contained to one unit and of short duration.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Lady Wigram has documented systems in place to ensure the use of restraint is actively minimised and is used as a last resort only. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. At the time of the audit there were no residents requiring restraint or enablers. The service is committed to maintaining a restraint-free environment. The clinical manager is the designated restraint coordinator. There is a restraint committee in place, which review processes six monthly. There was evidence in the meeting minutes that restraint and enabler use is a regular agenda item. Staff have received training in restraint minimisation and challenging behaviour management.</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 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	<p>The health and safety committee meet at the time of the quality meeting to review the accident/incident reports. There are online hazard identification forms available, however there was no evidence of formal hazard identification of a new identified hazard related to the fire doors (ground floor). All residents were found inside the building therefore it is a lower risk. The incidents occurred within the first few days when the dementia unit moved to the ground floor (between 25 June and 1 July 2021). Meeting minutes identified that the issue was discussed with staff and resolved in the minutes. There had been no reported incidents related to absconding from this door (and other) since the implementation of corrective actions to mitigate current and future risk.</p>	<p>Three incidents of residents in the dementia unit absconding through a fire door had not been formally documented on a hazard identification form and in the hazard register.</p>	<p>Ensure all hazards are identified and included on the hazard register actions implemented to mitigate the risk.</p> <p>90 days</p>

<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>Orientation is available to new staff employed at Lady Wigram Retirement Village. The care facility opened in November 2020. Nine staff files were reviewed. General orientation includes aspects of health and safety including hazard identification and management, emergency procedures, incident reporting, resident rights, infection control competency, hoist competency and equipment safety. A self-directed learning package comes with the orientation documents and includes cultural awareness, the ageing process, observation and documentation, management of challenging behaviours and communication. Lady Wigram Village orientation policy stated all orientation documentation including the self-directed learning package needs to be completed within 6 weeks and followed by a 90-day evaluation or performance review, however, evidence in files reviewed demonstrated that this is not always occurring.</p> <p>Caregivers and RNs interviewed confirmed they receive orientation, verbal feedback on their performance and they felt supported during the orientation process. The care facility manager and general manager interviewed understand human resource processes, requirements and related policies.</p>	<p>(1) Orientation documentation was not found in four (three registered nurses and one caregiver) of nine staff files reviewed and one orientation package was not signed off and received within the required timeframe.</p> <p>(2) All staff files reviewed did not have a 90-day performance review completed as per policy.</p> <p>(3) The infection control coordinator did not have a job description for infection control to describe her role and responsibilities.</p>	<p>(1) Provide evidence that orientation has occurred, and orientation is completed within the stated timeframe.</p> <p>(2) Establish a formal process to complete 90-day performance reviews/evaluation as per the in-house policy.</p> <p>(3) Ensure the job description to describe the roles and responsibilities of the infection control coordinator is on file.</p> <p>60 days</p>

<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The electronic care plans documented were integrated and resident centred, however, not all interventions were included in the care plans reviewed.</p>	<p>(1) One hospital resident with challenging behaviours did not have resident specific de-escalation and diversion strategies documented in the care plan.</p> <p>(2) There were no interventions, preferences or affiliations documented in the care plan for one hospital level resident who identified as Māori.</p> <p>(3) Two hospital residents did not have interventions or comfort measures around infections documented.</p> <p>(4) One hospital resident admitted for end-of-life care did not have an end-of-life care</p>	<p>(1)-(9) Ensure all care plan interventions are current, individualised and are included in the appropriate care plans.</p> <p>60 days</p>
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			<p>plan documented.</p> <p>(5) One hospital and one rest home resident did not have non-pharmaceutical interventions for pain relief included in the care plan.</p> <p>(6) There were no interventions documented to guide staff for a rest home level resident wearing compression hosiery.</p> <p>(7) Instructions documented in the GP consult notes were not included in the care plan for a rest home resident with dermatitis, and a dementia level resident who is an insulin dependent diabetic.</p> <p>(8) There were no signs and</p>	
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			<p>symptoms around hyperglycaemia or hypoglycaemia, and no expected blood sugar level ranges were documented for one rest home resident and one resident in the dementia unit who are insulin dependent diabetics.</p> <p>(9) There were no interventions or potential side effects documented for a rest home level resident on warfarin.</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 desired outcomes.</p>	PA Low	<p>An electronic wound assessment and management plan had been documented for all current wounds. Photographs have been taken periodically (scanned onto the system) for residents with chronic wounds, however, not all wound evaluations were consistently documented and there were more than one wound per chart on two charts reviewed.</p>	<p>(i) Two wound charts reviewed had more than one wound documented on the chart.</p> <p>(ii) Five of eleven wound charts reviewed</p>	<p>(i) Ensure all wounds have individual wound charts documented.</p> <p>(ii) Ensure wound evaluations documents progression</p>

			did not consistently document progression or deterioration towards healing.	towards healing. 90 days
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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.