

Lady Wigram Limited - Lady Wigram Village

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to Manatū Hauora (the Ministry of Health).

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Lady Wigram Limited
Premises audited:	Lady Wigram Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 11 January 2024 End date: 12 January 2024
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:	126

Executive summary of the audit




Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou motika | our rights
- hunga mahi me te hanganga | workforce and structure
- ngā huarahi ki te oranga | pathways to wellbeing
- te aro ki te tangata me te taiao haumarū | person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita | infection prevention and antimicrobial stewardship
- here taratahi | restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All subsections applicable to this service are fully attained with some subsections exceeded
	No short falls	Subsections applicable to this service are fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some subsections applicable to this service are partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some subsections applicable to this service are unattained and of moderate or high risk

General overview of the audit

Lady Wigram is certified to provide hospital (geriatric and medical), dementia and rest home levels of care for up to 140 residents. There were 126 residents at the time of the audit.

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

The care facility manager and clinical manager are appropriately qualified and experienced. There are quality systems and processes being implemented. Feedback from residents and families/whānau was positive about the care and the services provided.

The service has not yet addressed six previous audit shortfalls. Improvements continue to be required around corrective actions; care planning timeframes; evaluations; interventions and monitoring; and aspects of medication management.

This surveillance audit identified further improvements required around: business plan objectives/goals; meetings; and two-yearly mandatory training.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people’s rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Subsections applicable to this service are fully attained.
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A Māori health plan is in place for the organisation. The service provides an environment that supports residents’ rights, and culturally safe care. Details relating to the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers Rights (the Code) is included in the information packs given to new or potential residents and family/whānau. A Pacific health and wellbeing action plan (Ola Manuia) is in place. Residents and family/whānau interviewed confirmed that they are treated with dignity and respect. There is an established system for the management of complaints that meets guidelines established by the Health and Disability Commissioner.

Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.
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A business plan 2022-2024 is documented. There is a quality and risk management programme implemented. Quality data is discussed at facility meetings. An annual resident/relative satisfaction survey is completed. There are human resources policies which cover recruitment, selection, orientation and staff training and development. A recruitment and orientation procedure is in place. Caregivers are buddied with more experienced staff during their orientation. A staff education/training programme is being

implemented. Hazards are identified with appropriate interventions implemented. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Ngā huarahi ki te oranga | Pathways to wellbeing

<p>Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.</p>		<p>Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses are responsible for each stage of service provision. Care plans demonstrate service integration. The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Resident files included medical notes by the contracted nurse practitioner and visiting allied health professionals. The organisation uses an electronic medicine management system for e-prescribing, and administration of medications. The nurse practitioner is responsible for all medication reviews. Staff involved in medication administration are assessed as competent to do so. The food service caters for residents' specific dietary likes and dislikes. Residents are referred or transferred to other health services as required.

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

<p>Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.</p>		<p>Subsections applicable to this service are fully attained.</p>
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The building holds a current warrant of fitness. There is a planned and reactive maintenance programme in place.

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

Includes five subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.		Subsections applicable to this service are fully attained.
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An infection control programme is documented for the service. Staff have attended education around infection control. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. There have been three outbreaks since the previous audit.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service are fully attained.
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The service is committed to achieving a restraint-free service. This is supported by the governing body and policies and procedures. Staff interviewed demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-

escalation techniques and alternative interventions to prevent the use of restraint. There were residents using restraint on the days of the audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	13	0	2	3	0	0
Criteria	0	40	0	3	6	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Ngā paerewa Health and disability services standard

The following table contains the results of all the subsections assessed by the auditors at this audit. Depending on the services they provide, not all subsections are relevant to all providers and not all subsections are assessed at every audit.

For more information on the standard, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	FA	<p>A Māori health plan policy is documented for the service and acknowledges Te Tiriti o Waitangi as a founding document for New Zealand and the provision of services based on the principles of mana motuhake. There is a documented commitment to recognising and celebrating tāngata whenua in a meaningful way through partnerships, educational programmes, and employment opportunities. Residents are involved in providing input into their care planning, their activities, and their dietary needs. Staff have completed training around cultural safety and Te Tiriti o Waitangi.</p>
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.</p>	FA	<p>Lady Wigram Village has a policy based on the Pacific Health and Wellbeing Plan (Ola Manuia) 2020-2025 that encompasses the needs of Pasifika and addresses the Ngā Paerewa Health and Disability Services Standard. The aim is to uphold the principles of Pacific people by acknowledging respectful relationships and embracing cultural and spiritual beliefs and providing high quality healthcare. The cultural training provided included Pasifika cultures.</p>

<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>The Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. Seven residents interviewed (five hospital and two rest home) and two family/whānau (both dementia) reported that all staff respected their rights and that they were supported to know and understand their rights. Care plans reviewed were resident centred and evidenced input into their care and choice/independence. Staff completed training on the Code of Rights in August 2023.</p>
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	FA	<p>An abuse and neglect policy is being implemented. Lady Wigram Village policies prevent any form of discrimination, coercion, harassment, or any other exploitation. Code of conduct is discussed and signed by staff during their induction to the service. The code of conduct addresses harassment, racism, and bullying. Staff sign to acknowledge that they accept the code of conduct as part of the employment process. Staff complete education on orientation and annually as per the training plan on how to identify abuse and neglect. Staff are educated on how to value the older person, showing them respect and dignity. All residents and families/whānau interviewed confirmed that the staff are caring, supportive and respectful. There are policies in place to manage residents property and money.</p> <p>Professional boundaries are defined in job descriptions. Interviews with registered nurses (RN) and caregivers confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation. Interviews with seventeen staff (seven caregivers, two clinical coordinators, five RN's, one care facility administrator, one education coordinator and one chef) and two managers (one care facility manager and one clinical manager) described a positive culture of teamwork.</p>
<p>Subsection 1.7: I am informed and able to make choices</p> <p>The people: I know I will be asked for my views. My choices will be respected when making decisions about my</p>	FA	<p>There are policies documented around informed consent. Informed consent processes were discussed with residents and family/whānau on admission. Eight electronic resident files, including respite agreements, were reviewed</p>

<p>wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p> <p>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.</p>		<p>and consents included in the admission agreement sighted for outings, photographs, release of medical information, medication management and medical cares were included and signed as part of the admission process. Specific consent forms had been signed by residents or their activated enduring power of attorney (EPOA) for procedures, such as vaccines and other clinical procedures.</p>
<p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p> <p>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>	<p>FA</p>	<p>The complaints procedure is equitable and is provided to residents and relatives on entry to the service. The care facility manager maintains a record of all complaints, both verbal and written, by using a complaint register. There have been thirteen complaints made in 2023 and one complaint received in 2024 year to date. The complaint documentation, including acknowledgement, investigation, follow-up letters and resolution, demonstrate that complaints are managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). One of the complaints made in July 2023 was lodged through the Health and Disability Commission (HDC). The complaint was reviewed by the temporary management team, the allegations were not substantiated.</p> <p>Discussions with residents and family/whānau confirmed they were provided with information on complaints and complaints forms are available at the entrance to the facility. Residents have a variety of avenues they can choose from to make a complaint or express a concern, including the resident meetings which are held monthly. Communication is maintained with individual residents, with updates at activities and mealtimes and one on one reviews. Residents and relatives making a complaint can involve an independent support person in the process if they choose. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. The care facility manager and clinical manager acknowledged the understanding that for many Māori, there is a preference for face-to-face communication and confirmed their commitment to do this wherever possible. On interview, residents and family/whānau stated they</p>

		felt comfortable to raise issues of concern with management at any time.
<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	PA Low	<p>Lady Wigram Village is located in Christchurch and is part of a wider village. The service provides care for up to 140 residents at hospital, rest home and dementia level care. At the time of the audit there were 126 residents in total.</p> <p>The rest home unit has 40 dual purpose beds and there were 39 rest home residents, including one resident on respite care and one resident on an ACC contract respite. The hospital unit has 60 dual-purpose beds and there were 46 hospital and three rest home residents in total: including three hospital residents on end-of-life contracts. There are two secure dementia units; the Corsair unit has 20 beds with 20 dementia residents, and the Skyhawk unit has 20 beds with 18 dementia residents.</p> <p>Lady Wigram Village’s organisational culture is underpinned by social, cultural, and professional diversity. The care facility manager has connections with a local marae and an understanding of Kaupapa Māori within the sector. Lady Wigram Village has an organisational business plan 2022-2024 in place; however, specific objectives/goals documented were not evidenced as being reviewed annually or regularly throughout the year. The business plan does reflect a leadership commitment to collaborate with Māori, aligns with the Ministry of Health strategies and addresses barriers to equitable service delivery. The working practices at Lady Wigram Village are holistic in nature, inclusive of cultural identity, spirituality and respect the connection to family/ whānau and the wider community as an intrinsic aspect of wellbeing and improved health outcomes for tāngata whaikaha.</p> <p>Lady Wigram Village is a family-owned business. There is a director/owner, whose daughter is the general manager and oversees the Lady Wigram Village facility. The care facility manager and clinical manager report to the general manager. The director/owner visits the site on a regular basis and meets monthly with the general manager, care facility manager, and clinical manager to discuss the link between management and governance. When on site, both the director and general manager actively engage with residents and staff as evidenced through observations and interviews. The care facility manager, who is a RN, and clinical manager have both been in their roles since August 2023. They are supported by three clinical</p>

		<p>coordinators (one clinical coordinator was absent at the time of the audit), care facility administrator and finance manager. Collaboration with the general manager, care facility manager, clinical manager and staff who identify as Māori reflect their input for the provision of equitable delivery of care and organisational operational policies.</p> <p>The facility was put into temporary management for a month in July with the departure of the previous care facility manager and clinical manager. The organisation is focused on providing respectful end of life care that caters to physical, cultural, and spiritual needs, as evidenced by compliments from family/whānau. The management team are in active discussions to discuss and address barriers related to Māori culture and health.</p> <p>The care facility manager and clinical manager have completed eight hours of professional development activities related to managing an aged care facility, including cultural training to ensure they are able to demonstrate expertise in Te Tiriti, health equity and cultural safety.</p>
<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>	<p>PA Moderate</p>	<p>Lady Wigram Village is implementing a quality and risk management programme, including performance monitoring through internal audits and collection of clinical indicator data. Clinical indicator data is collected, analysed, and cascaded for discussion in facility meetings. Quality data and trends in data are posted on quality noticeboards. On interview, staff were aware of quality data indicator results. Internal audits are completed as per the internal audit schedule. Corrective actions are documented to address any improvements, with evidence of progress and sign off when achieved; however, not all corrective actions were followed up and closed out. The previous partial attainment #2.2.2 continues to require improvement.</p> <p>Resident and family/whānau satisfaction surveys are completed annually and the latest surveys were completed in November 2023. The surveys reflected high levels of impression of surroundings, rooms/grounds, privacy/dignity, respect and hygiene/cleanliness. Survey results were shared with family/whānau, residents and staff.</p> <p>There is an annual meeting schedule in place; however, not all quality improvement, staff and RN/clinical meetings have been completed as per the required schedule policy. The quality improvement, staff and RN/clinical meetings provide an avenue for discussions in relation to (but not limited to)</p>

		<p>quality data; health and safety; infection control/pandemic strategies; complaints/compliments received (if any); staffing; and education. Meeting minutes and quality data graphs are also posted in the staffroom. Policies are regularly reviewed by an external consultant and reflect updates to the 2021 Ngā Paerewa Standard. Review of policies and quality data provide a critical analysis of practice to improve health equity. New policies or changes to a policy are communicated and discussed to staff. Staff complete cultural competency questionnaires to ensure a high-quality service and cultural safe service is provided for Māori.</p> <p>A health and safety system is in place with annual identified health and safety goals. There is a health and safety officer who has completed formal health and safety training. There is an up-to-date hazard register in place for all areas (hospital, rest home, dementia, household, maintenance and kitchen). Any new hazards identified within the area are added onto the area hazard register (sighted). The previous partial attainment #2.2.4 has been addressed. A staff noticeboard keeps staff informed on health and safety. Staff and external contractors are orientated to the health and safety programme. There are regular manual handling training sessions for staff. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form. All resident incidents are recorded with incident data collated monthly and analysed. All resident incidents are recorded on the electronic resident management system. Relatives are notified in a timely manner. Results of incidents are collated and benchmarked with quality data monthly.</p> <p>Discussions with the care facility manager and clinical manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been seven Section 31 notifications completed for one care facility manager change in August 2023; two clinical manager changes in May and August 2023; one pressure injury (suspected deep tissue) in October 2023; and three missing residents in September, October and November 2023. There have been three Covid-19 outbreaks reported since the previous audit in March 2023. Management described outbreak management, notifications and staff debriefs.</p>
Subsection 2.3: Service management	PA Low	Lady Wigram Village organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. There is casual staff to cover

<p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	<p>unplanned absences. The roster provides sufficient and appropriate coverage for the effective delivery of care and support. The care facility manager, clinical manager and general manager work Monday to Friday. They are supported by three clinical coordinators and a team of RNs. There is RN cover over 24 hours a day.</p> <p>Staff and residents are informed when there are changes to staffing levels, and care requirements are attended to in a timely manner, as evidenced in staff interviews. 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. The caregivers interviewed reported the RNs are supportive and approachable. Interviews with residents and relatives indicated that overall, there are sufficient staff to meet resident needs. There are separate laundry and cleaning staff.</p> <p>There is an annual education and training schedule being implemented; however, not all two-yearly mandatory training has been completed. The service supports caregivers to obtain a New Zealand Qualification Authority (NZQA) qualification. Eighty-six caregivers are employed. Thirty-nine caregivers have achieved a level 4 NZQA qualification, twenty-one have achieved level 3 and five have achieved level 2. There is a care staff educator who works closely with staff to ensure attainment of qualifications. Sixteen caregivers work in the dementia unit and ten have achieved their dementia unit standards; six are enrolled and in the process of completing the standards. All have been employed less than the required eighteen month period. The previous partial attainment #2.3.4 has been addressed.</p> <p>All staff are required to complete competency assessments as part of their orientation. All caregivers are required to complete annual competencies for hand hygiene, correct use of personal protective equipment, medication administration (if medication competent) and moving and handling. A record of completion is maintained. Additional RN specific competencies include syringe driver, and an interRAI assessment competency. Ten out of fourteen RNs are interRAI trained. All care staff are encouraged to also attend external training, webinars and zoom training where available. Staff are encouraged to participate in learning opportunities that provide them with up-to-date information on Māori health outcomes and disparities.</p>
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<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	<p>FA</p>	<p>There is a recruitment process which includes interviews, reference checking, signed employment contracts, job descriptions, police checking and completed orientation. Nine staff files were reviewed (one care facility manager, one clinical manager, two clinical coordinators, four caregivers and one activities coordinator) and evidenced that staff who had been employed for over one year had an up-to-date annual performance appraisal. The previous partial attainment #2.4.4 has been addressed. There was also evidence of a job description and orientation being completed in place for the current infection control coordinator. The previous partial attainment #2.4.5 has been addressed.</p> <p>The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying with a more experienced staff member when first employed. Competencies are completed at orientation. All 90-day evaluations were completed as per in-house policy. The service demonstrates that the orientation programme supports RNs and caregivers to provide a culturally safe environment to Māori. A register of practising certificates is maintained for all health professionals.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>PA Moderate</p>	<p>Eight resident files were reviewed; four hospital level residents (including one on an end-of-Life contract), two dementia level residents, and two rest home residents (including one on an ACC respite agreement and one on a respite contract). The RNs are responsible for conducting all assessments and for the development of care plans. There was evidence of resident and family/whānau involvement in the interRAI assessments and long-term care plans reviewed and this was documented in progress notes, six-monthly care review electronic form, and family/whānau contact forms. Family/whānau interviewed stated they are involved in the development and evaluation of the care plan.</p> <p>All residents have admission assessment information collected and an interim plan completed at time of admission. Initial interRAI assessments were completed where required (the respite, ACC and palliative residents did not require interRAI assessments); however, not all were completed within three weeks of admission, and not all interRAI reassessments and</p>

	<p>care plan reviews have been completed within the required timeframes in the last year. The previous partial attainment # 3.2.1 continues to require improvement. Additionally, all files had a suite of assessments (including activities, cultural, and dietary assessments) completed to form the basis of the long-term care plan or initial care plan.</p> <p>Additional risk assessment tools include behaviour and wound assessments as applicable; however, the outcomes of risk assessments are not always reflected in the care plan in sufficient detail to guide staff in the management of the care of the resident. The previous partial attainment # 3.2.3 continues to require improvement. Evaluations did not always reflect progress towards care goals. The previous partial attainment # 3.2.5 continues to require improvement. Short-term care plans are utilised for acute issues, including (but not limited to) weight loss, infections, and acute wounds.</p> <p>All residents had been assessed by the nurse practitioner (NP) within five working days of admission. The NP service visits four days a week, reviews residents at least three monthly and provides out of hours cover. The NP (interviewed) commented positively on the communication and quality of care at the facility. Specialist referrals are initiated as needed. Allied health interventions were documented and integrated into care plans. The service contracts with a physiotherapist 16 hours a week and a podiatrist visits every six to eight weeks. Specialist services, including mental health, dietitian, speech language therapist, gerontology nurse specialist, wound care, and continence specialist nurse, are available as required through Te Whatu Ora -Waitaha Canterbury or the Nurse Maude service.</p> <p>Care staff interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery. Progress notes are written electronically every shift and as necessary by caregivers and at least weekly by the RNs. The RNs further add to the progress notes if there are any incidents or changes in health status.</p> <p>Residents interviewed reported their needs and expectations were being met, and family members confirmed the same regarding their whānau. When a resident's condition alters, the staff alert the RN who then initiates a review with a NP. Family/whānau stated they were notified of all changes to health, including infections, accident/incidents, GP visit, medication changes and any changes to health status, and this was consistently documented on the electronic resident record.</p>
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		<p>There were 26 current wounds (including pressure injuries, skin tears, abrasions, lesions a surgical wounds). A sample of eight wounds, including three pressure injuries reviewed had comprehensive wound assessments, including photographs to show the healing progress. An electronic wound register is maintained, and wound management plans are implemented. There is access to the Nurse Maude clinical nurse specialist. There were five pressure injuries at the time of the audit (one resident had two non-facility acquired unstageable pressure injuries, and two facility acquired stage II pressure injuries. One resident had a facility acquired stage II pressure injury). Caregivers and RNs interviewed stated there are adequate clinical supplies and equipment provided, including wound care supplies and pressure injury prevention resources. Continence products are available and resident files included a continence assessment, with toileting regimes and continence products identified for day use and night use.</p> <p>Caregivers and the RNs complete monitoring charts, including bowel chart; reposition charts; vital signs; weight; food and fluid chart; blood glucose levels; and behaviour as required; however, not all repositioning charts were completed in required timeframes. The previous partial attainment #3.2.4 continues to require improvement. Incident and accident reports reviewed evidenced timely RN follow up, and relatives are notified following adverse events (confirmed in interviews). Opportunities to minimise future risks are identified by the clinical coordinator or clinical manager, who reviews every adverse event before closing. Neurological observations have been completed as per the falls management policy and neurological observation policy.</p>
<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies available for safe medicine management that meet legislative requirements. Staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. The RNs and caregivers interviewed could describe their role regarding medication administration. The service uses blister packs for all medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>The effectiveness of 'as required' medications is recorded in the electronic medication system and in the progress notes. All medications are stored securely in the four dedicated medication rooms. Medications reviewed</p>

		<p>were appropriately stored in the medication trolley and medication rooms. The medication fridge and medication room temperatures are monitored daily; however, recent room temperatures were not always within acceptable ranges. The previous partial attainment #3.4.1 continues to require improvement. Expired medicines were being returned to the pharmacy promptly. All eyedrops have been dated on opening and discarded as per manufacturer's instructions. This portion of the previous shortfall # 3.4.1 has been met.</p> <p>Sixteen electronic medication charts were reviewed. The medication charts reviewed identified that the NP had reviewed all resident medication charts three-monthly and each medication chart has photo identification and allergy status identified. There are two residents self-administering their medications in the hospital home that are deemed competent with three-monthly competency reviews, and their medication is safely stored. The previous partial attainment #3.4.6 has been addressed. The medication policy describes the procedure for self-medicating residents, and this has been implemented as required. There are no standing orders in use. Medication incidents were completed in the event of a drug error and corrective actions were acted upon. A sample of these were reviewed during the audit.</p>
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	FA	<p>Residents' nutritional requirements are assessed on admission to the service in consultation with the residents and family/whānau. The nutritional assessments identify residents' personal food preferences, allergies, intolerances, any special diets, cultural preferences, and modified texture requirements. A daily menu review ensures residents receive their special diets and food preferences. Copies of individual dietary preferences were available in the kitchen folder. A food control plan is in place and expires in June 2024.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</p> <p>The people: I work together with my service provider so they know what matters to me, and we can decide what best</p>	FA	<p>A standard transfer notification form is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families/whānau were involved in all discharges to and from the service</p>

<p>supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.</p>		<p>and there was sufficient evidence in the residents' records to confirm this. Records sampled evidenced that the transfer and discharge planning included risk mitigation and current residents' needs. The discharge plan sampled confirmed that, where required, a referral to other allied health providers to ensure the safety of the resident was completed.</p>
<p>Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>	<p>FA</p>	<p>Appropriate systems are in place to ensure the resident's physical environment and facilities are fit for purpose. The current building warrant of fitness expires 1 February 2024. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. All electrical equipment is tested and tagged, and bio-medical equipment is calibrated. The previous partial attainment #4.1.1 has been addressed. Water temperatures were monitored and recorded. Residents and family/whānau interviewed were happy with all aspects of the environment. Spaces were culturally inclusive and suited the needs of the resident groups.</p>
<p>Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	<p>FA</p>	<p>The infection prevention control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, and the training and education of staff. Policies and procedures are provided by an external consultant, with input from infection control specialists and reviewed by the management team. Policies are available to staff and linked to the quality system. Infection control is included in the internal audit schedule (link 2.2.2). The infection control programme is reviewed and reported on annually.</p> <p>The infection control policy states that Lady Wigram Village is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan.</p>

		<p>The infection control coordinator has undertaken recent education, including specific training on aged residential care infection control, and has additional support from expertise at Te Whatu Ora – Waitaha Canterbury. All staff have completed infection prevention and control in-services and associated competencies, such as handwashing and the use of personal protective equipment.</p>
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p>	<p>FA</p>	<p>The infection prevention control policy describes surveillance as an integral part of the infection prevention control programme. Monthly infection data is collected for all infections based on signs, symptoms, and the definition of the infection. Infections are entered into the electronic infection register and surveillance of all infections (including organisms) is collated onto a monthly infection summary. Reports include antibiotic use. This data is monitored and analysed for trends, monthly and annually. Lady Wigram Village incorporates ethnicity data into surveillance methods and data captured around infections. The previous partial attainment #5.4.3 has been addressed. Infection control surveillance results are discussed at staff meetings (link 2.2.3). Meeting minutes and data are available for staff. Action plans are completed for any infection rates of concern.</p> <p>Lady Wigram Village receives regular notifications and alerts from Te Whatu Ora – Waitaha Canterbury for any community concerns. There have been three Covid-19 outbreaks reported since the previous audit in March 2023. The facility followed their pandemic plan. All areas were kept separate, and staff were cohorted where possible. Staff wore PPE and residents and staff had rapid antigen (RAT) tests. Families/whānau were kept informed by phone or email. Visiting was restricted. Opportunities to improve management of the outbreaks had been identified in post outbreak meetings and in staff meetings and these were clearly documented. The previous partial attainment #5.4.4 has been addressed.</p>
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p>	<p>FA</p>	<p>An interview with the restraint coordinator described the organisation's commitment to restraint minimisation. This is supported by the management team and policies and procedures. On the days of audit there were four residents using bed rails and one resident using a lap belt. The restraint coordinator is an RN. Staff attend training in behaviours that challenge and</p>

<p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>		<p>de-escalation techniques. Alternatives to restraint, behaviours that challenge, and residents who are a high falls risk are discussed at quality and staff meetings. The use of restraint and how it is being monitored and analysed is reported at quality and staff meetings. A comprehensive assessment, approval, monitoring, and quality review process is documented for all use of restraint. When restraint is considered, the facility works in partnership with Māori, to promote and ensure services are mana enhancing.</p>
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Specific results for criterion where corrective actions are required

Where a subsection is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the subsection. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 2.1.2</p> <p>Governance bodies shall ensure service providers’ structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.</p>	PA Low	Lady Wigram Village has an organisational business plan 2022-2024 in place; however, there was no evidence specific objectives/goals were reviewed annually or regularly throughout the year.	There is a business plan in place; however, specific objectives/goals were not evidenced as being documented or reviewed annually or throughout the year.	<p>Ensure that the business plan has specific objectives/goals documented as reviewed annually and regularly throughout the year.</p> <p>90 days</p>
<p>Criterion 2.2.2</p> <p>Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.</p>	PA Moderate	Lady Wigram Village is implementing a quality and risk management programme, including performance monitoring through internal audits and collection of clinical indicator data. Internal audits are completed as per the internal audit schedule. However,	Twenty-eight internal audits were reviewed, eighteen internal audits requiring corrective actions were not fully actioned or signed off as closed.	Ensure that all corrective actions are followed up and closed out.

		not all corrective actions were followed up and closed out.		60 days
<p>Criterion 2.2.3</p> <p>Service providers shall evaluate progress against quality outcomes.</p>	PA Low	There is an annual meeting schedule in place; however, not all quality improvement, staff and RN/clinical meetings have been completed as per the required schedule policy.	<p>i). Quality improvement, staff and RN/clinical meetings have not been held as per the required schedule policy.</p> <p>ii). Not all agenda items, discussion points and actions have been followed up or completed.</p>	<p>i). Ensure that quality improvement, staff and RN/clinical meetings are held as per the required schedule policy.</p> <p>ii). Ensure all agenda items, discussion points and actions are evidenced as followed up and completed.</p> <p>90 days</p>
<p>Criterion 2.3.4</p> <p>Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.</p>	PA Low	There is an annual education and training schedule being implemented for 2023; however, not all two yearly mandatory training has been completed.	There was no evidence of mandatory training provided for the following: sexuality/intimacy, spirituality/counselling, the aging process, death/Tangihanga, advocacy, abuse and neglect, and privacy/dignity.	<p>Ensure that all two yearly mandatory training is conducted for all staff.</p> <p>90 days</p>
<p>Criterion 3.2.1</p> <p>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.</p>	PA Moderate	Initial assessments and care plans have been developed within the required timeframes for all eight files reviewed. Initial interRAI assessments have not always been completed within the required timeframes. Long-term cares plans had been developed for all residents; however, these had not always been documented with 21	<p>i). Three of eight files reviewed did not have a long-term care plan documented within three weeks of admission (two files did not require long term care plans).</p> <p>ii). InterRAI assessments were not completed within 21 days of admission for two of four residents</p>	<p>i). Ensure long-term care plans are documented with 21 days of admission.</p> <p>ii). Ensure initial interRAI assessments are completed within three weeks of</p>

		<p>days of admission. Six-monthly interRAI reassessments and long-term care plan reviews had been completed for three residents; however, these were not completed within expected timeframes. The service was aware of documentation delays and a corrective action plan had been documented and reviewed at the time of audit with confirmation of good progress.</p>	<p>who required interRAI assessments.</p> <p>iii). InterRAI reassessments were not completed as scheduled for two of three residents where reviews were required over the previous year.</p> <p>iv). Six-monthly evaluations were not completed within required timeframes for three of three files where reviews were required.</p>	<p>admission.</p> <p>iii). Ensure interRAI reassessments are completed six-monthly.</p> <p>iii). Ensure care plan evaluations are completed at least six-monthly.</p> <p>30 days</p>
<p>Criterion 3.2.3</p> <p>Fundamental to the development of a care or support plan shall be that:</p> <p>(a) Informed choice is an underpinning principle;</p> <p>(b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan;</p> <p>(c) Comprehensive assessment includes consideration of people's lived experience;</p> <p>(d) Cultural needs, values, and beliefs are considered;</p> <p>(e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia;</p> <p>(f) Strengths, goals, and</p>	<p>PA</p> <p>Moderate</p>	<p>The electronic resident management system includes assessments that addresses needs, values, individual preferences, and beliefs of residents; however, not all assessments were fully reflected in the residents' care plans. Four of eight resident care plans reviewed identified sufficient interventions to guide the resident's current care needs.</p>	<p>i). Two hospital residents with ongoing pain had no non-pharmaceutical interventions documented to manage pain or discomfort.</p> <p>ii). One hospital level care resident assessed as a moderate falls risk did not have interventions documented to manage the risk.</p> <p>iii). One hospital level care resident assessed by speech language therapy as requiring a puree diet with upright positioning did not have interventions documented to manage the risk.</p>	<p>i). - iii) Ensure all care plan interventions are current, individualised and reflect the assessed needs of residents.</p> <p>30 days</p>

<p>aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated;</p> <p>(g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention;</p> <p>(h) People's care or support plan identifies wider service integration as required.</p>				
<p>Criterion 3.2.4</p> <p>In implementing care or support plans, service providers shall demonstrate:</p> <p>(a) Active involvement with the person receiving services and whānau;</p> <p>(b) That the provision of service is consistent with, and contributes to, meeting the person's assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective;</p> <p>(c) That the person receives services that remove stigma and promote acceptance and inclusion;</p> <p>(d) That needs and risk assessments are an ongoing</p>	<p>PA Moderate</p>	<p>The service has access to a range of both paper-based and electronic monitoring forms. Monitoring forms included (but were not limited to): repositioning charts; food and fluid intake; restraint monitoring; weight; neurological observations; wound management; and behaviour. Review of monitoring charts identified these were utilised but not all charts were maintained as planned.</p>	<p>Two of two repositioning charts reviewed for hospital residents did not evidence completion as planned.</p>	<p>Ensure monitoring is completed as scheduled.</p> <p>30 days</p>

process and that any changes are documented.				
<p>Criterion 3.2.5</p> <p>Planned review of a person's care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;</p> <p>(b) Include the use of a range of outcome measurements;</p> <p>(c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations;</p> <p>(d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented;</p> <p>(e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.</p>	<p>PA Moderate</p>	<p>As per policy, the RN is responsible for assessments and documentation of care plans. There was evidence of assessment updates and evaluations conducted for some residents with changes to care plans made in 2023, with documentation to support resident's progression towards meeting goals. One resident evidenced progress towards goals. Five residents did not require long-term care plan reviews. Short-term care plans were evaluated regularly as required.</p>	<p>Two of three care plan evaluations did not reflect progress towards the goals.</p>	<p>Ensure that care plan evaluations reflect progress towards the goals.</p> <p>60 days</p>
<p>Criterion 3.4.1</p> <p>A medication management system shall be implemented appropriate to the scope of the service.</p>	<p>PA Moderate</p>	<p>Medications policies align with current medication guidelines and legislation. Registered nurses and medication competent caregivers are responsible for all aspects of medication storage</p>	<p>The temperatures of two medication rooms (rest home and dementia units) evidenced temperatures above 25 degrees on three and four occasions over</p>	<p>Ensure medications rooms are monitored as per policy and corrective actions implemented when</p>

		and administration. Systems are in place to ensure staff competency and safe storage is monitored by regular checks and internal audits; however, not all mediation room temperatures were managed in line with policy; this is an ongoing shortfall.	recent weeks, with no corrective actions.	outside documented ranges. 30 days
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Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this audit.

No data to display

End of the report.