# The Wood Lifecare (2007) Limited - The Wood Lifecare

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

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

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** The Wood Lifecare (2007) Limited

**Premises audited:** The Wood Lifecare (2007) Ltd

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 30 August 2016 End date: 31 August 2016

**Proposed changes to current services (if any):** This audit assessed the service’s preparedness for the addition of Hospital – medical services and the reconfiguration of 13 existing hospital beds currently located in the hospital wing into dual service beds.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 73

# 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 |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

The Wood Lifecare is part of the Arvida group of residential aged care facilities and provides hospital and rest home level care for up to 115 residents. On the day of the audit, there were 73 residents at these levels of care.

The service is overseen by an experienced village manager, who has been in the role since 2009. The village manager is supported by a clinical manager, who has been in the role since June 2015. The Wood Lifecare is supported by the Arvida general manager wellness and care. Residents and the families interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

This audit also assessed the preparedness of the service to provide hospital – medical services level of care and the reconfiguration of 13 hospital beds into dual services beds. This audit verified there are appropriate processes and staffing levels for providing hospital medical services and for the reconfiguration of the current beds into dual-purpose beds.

The audit identified the following areas requiring improvement: informed consent, care plan interventions, neurological observations following incidents.

The service is commended for achieving a continued improvement rating around the activities programme, processes to discharge residents and infection control.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Staff at The Wood Lifecare strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights (the Code). Residents’ cultural needs are met. Policies are implemented to support residents’ rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

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| --- | --- | --- |
| 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. |

The quality and risk management programme includes service philosophy, goals and a quality/business planner. Meetings are held to discuss quality and risk management processes. Residents/family meetings are held regularly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Falls prevention strategies are in place that includes the analysis of falls incidents. An education and training programme has been implemented with a current training plan in place for 2016. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The village manager takes primary responsibility for managing entry to the service with assistance from the clinical manager. Comprehensive service information is available. Initial assessments are completed by a registered nurse. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored and managed appropriately in line with legislation and guidelines. The general practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## Safe and appropriate environment

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| --- | --- | --- |
| 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 warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy with ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounges and two dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and laundry staff are providing appropriate services. There is a planned and reactive maintenance programme in place. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster. All registered nurses hold a current first aid certificate.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

The Wood Lifecare has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. Three residents were assessed as requiring restraints and two residents were using an enabler. The clinical manger is the designated restraint coordinator.

## Infection prevention and control

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| --- | --- | --- |
| 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 3 | 43 | 1 | 2 | 1 | 0 | 0 |
| **Criteria** | 3 | 94 | 1 | 2 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with 20 staff (six caregivers, five registered nurses, one enrolled nurse, two diversional therapists, one physiotherapist, one cook, one maintenance person, two laundry persons and one cleaner) confirm their familiarity with the Code. Interviews with ten residents (nine rest home and one hospital) and seven families (one rest home and six hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written general consents. Nine resident files sampled (four rest home – including one resident in the serviced apartments, and five hospital including one resident admitted under a non-aged related contract) demonstrated that advanced directives are signed for separately. Not all advanced directives and resuscitation decision forms were fully completed. Informed consent forms were completed. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members interviewed confirmed that they are involved in decisions that affect their relative’s lives. All nine resident files sampled had a signed admission agreement signed on or before the day of admission. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy that describes the management of complaints process and complaints forms are available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. There is a complaints register. Verbal and written complaints are documented. Five complaints have been made in the past 12 months. All complaints reviewed had noted investigation, timeframes and corrective actions when and where required, and resolutions were in place. Results are fed back to complainants. All staff interviewed were able to describe the process around reporting complaints.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the village manager discusses the information pack with the resident and the family/whānau. The information pack incudes a copy of the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident’s privacy and could describe how they manage maintaining privacy and respect of personal property. A policy describes spiritual care. Church services are conducted regularly. Residents interviewed indicated that resident’s spiritual needs are being met when required.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. One resident identified as Māori at the time of the audit. There was no documentation around Tikanga practises in the care plan for the Māori resident (link 1.3.6.1). Discussions with staff confirm that they are aware of the need to respond to cultural differences.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident’s beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural safety/awareness. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident. Full and frank open disclosure occurs. Incident/accidents forms reviewed had documented evidence of family notification or noted if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member’s health status. A residents/relatives meeting occurs every three months and issues arising from the meeting are communicated to staff. Any issues raised from these meetings are investigated by the village manager and there was evidence of implemented corrective actions. Interpreter services are available as required.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Wood Lifecare is owned and operated by the Arvida Group. The service provides care for up to 115 residents within 30 rest home beds, 47 hospital level beds and 38 serviced apartments certified to provide rest home level care. On the day of the audit there were 73 residents including; 30 rest home residents, 36 hospital residents including one younger persons disabled (YPD), and 7 rest home residents in the serviced apartments. There were no residents on respite care. All other residents were admitted under the aged related residential care contact (ARRC). Thirteen rooms within the 47-bed hospital area have been verified as appropriate for dual-purpose (rest home or hospital level). This audit verified that the service has appropriate processes, facilities and staffing to provide hospital - medical care. There were no residents receiving hospital medical care on the days of audit. The village manager is an experienced registered nurse and manager and has been in the role for seven years. She is supported by a clinical manager who has been in the position for one year and has been at The Wood Lifecare for three and a half years.The village manager provides a monthly report to the Arvida general manager operations on a variety of operational issues. Arvida has an overall business/strategic plan and The Wood Lifecare has an annual quality improvement and risk management action plan in place. The organisation has a philosophy of care, which includes a mission statement. The Wood Lifecare is currently transitioning to the Arvida Group quality management systems and Arvida policies and procedures. The village manager has completed in excess of eight hours of professional development in the past 12 months.This audit also included verifying the service as suitable to provide ‘medical’ level care under their current hospital certification. The service has links to allied health including physiotherapist. There is sufficient space in resident rooms and appropriate equipment is available. |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | In the absence of the village manager, the clinical manager is in charge. Support is also provided by the general manager operations, the general manager wellness and care and the care staff.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is a business/strategic plan that includes quality goals and risk management plans for The Wood Lifecare. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager advised that she is responsible for providing oversight of the quality programme on site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. The site-specific service's policies are being transitioned over to the Arvida Group polices, which will be reviewed at least every 2 years across the group. Head office sends new/updated policies. Staff have access to the policy manuals. The Wood Lifecare has implemented the Arvida Group InterRAI assessment policy. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system that is regularly reviewed. Restraint and enabler use (when used) is reported within the quality and clinical staff meetings. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Falls with injury were identified as an area that required improvement from data collected from July to December 2015. A plan was developed as part of their 2016 quality goals, which included increasing resident attendance and participation in The Wood exercise programme. The Wood expanded the exercise programme to instil a culture of holistic wellness and active lifestyle to the residents. Attendance for the expanded exercise programme in 2016 increased by 40% from 2015. The internal audit programme continues to be implemented and all issues identified had corrective action plans and resolutions. Staff interviewed could describe the quality programme corrective action process. There is an annual staff training programme that is implemented and based around policies and procedures and records of staff attendances maintained. Infection Control programme is implemented and all infections are documented monthly. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The 2015 resident relative survey overall result shows satisfaction with services provided. Resident/family meetings occur every three months and resident and family interviews confirmed this. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | PA Low | There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents. Fourteen incident forms reviewed demonstrated that not all appropriate clinical follow-up and investigation had occurred following incidents. Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Three section 31 incident notification forms (sighted) were completed in 2016. One matter had been referred to the police and two matters related to pressure injuries.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Negligible | There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Ten staff files were reviewed (one village manager, one clinical manager, two registered nurses, three caregivers, one housekeeper, one laundry and one head cook) and there is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation was evidenced and staff described the orientation programme. The in-service education programme for 2015 has been completed and the plan for 2016 is being implemented. This audit included verifying the service as suitable to provide ‘medical’ level care under their current hospital certification. Staff are well trained around current medical conditions. The village manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The Wood Lifecare policy includes staff rationale and skill mix. The service has a total of 98 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. In addition to the village manager and clinical manager who both work full time, there is at least one registered nurse and four caregivers on at any one time. The registered nurse on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirm there are sufficient staff to meet the needs of residents. There are sufficient staff rostered on to manage the care requirements of the residents including the reconfiguration of 13 existing hospital beds to be used for dual-purpose (either rest home or hospital). |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregiver or registered nurse.  |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The village manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the village manager and clinical manager. The admission agreement form in use aligns with the requirements of the ARRC contract.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | CI | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential aged care envelope (yellow) that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur. The service has a focus in restorative care to transition residents to a lower level of care and then to discharge home. The service actively works with the multidisciplinary team, the resident and the family to rehabilitate residents to transition back to the community and be discharged into their own homes.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Eighteen medication charts were reviewed (eight rest home and ten hospital). The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication fridge temperatures were being recorded. Resident’s medicines are stored securely in the medication room/cupboard. Medication administration practice complied with the medication management policy for the medication round sighted. Medication prescribed is signed as administered on the pharmacy generated signing chart. Registered nurses administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotic packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts correctly and there was evidence of three monthly reviews by the GP. Three rest home residents self-administer their own medicines. The self-administration documentation was correctly recorded and a competency assessment completed.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | There is a fully functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cook follow a rotating seasonal menu, which has been reviewed by an external dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.  |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The service records the reasons for declining service entry to residents should this occur, and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is given out. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled did not all have InterRAI assessments completed. There was evidence that some InterRAI assessments that had been completed were reviewed at least six monthly (link 1.2.7.5). The service advised that InterRAI assessments have not been completed for all residents. Five of thirteen registered nurses are InterRAI trained.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The long-term care plans reviewed are individualised. The InterRAI assessment process (where completed) informs the development of the resident’s care plan (link 1.3.4.2). The long-term care plan did not always describe the support required to meet the resident’s goals and needs as identified through the assessment process. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses (RNs) and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse [hospice nurse] or the mental health nurses). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management plans are in place for residents with wounds. Twenty-three wound care plans were reviewed for eight rest home residents with four skin tears, three chronic ulcers, and one lesion, and fourteen hospital residents including three skin tears, two facility acquired pressure injuries, five lesions, one blister, one laceration, and two chronic ulcers. All wounds have been reviewed at appropriate times. The RNs have access to specialist nursing wound care management advice through the district nursing service. Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | CI | Two diversional therapists are currently facilitating the activities programme for all residents. The programme is supported by a number of volunteers. The programme operates five days a week. Activities are available for the residents to access over the weekend. Each resident has an individual activities assessment on admission, which is incorporated into the InterRAI assessment process. An individual activities plan is developed for each resident by the diversional therapist in consultation with the registered nurses. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. The diversional therapists review the social profile and the recreational plan when the care plan is evaluated and if a further InterRAI assessment occurs. Residents interviewed commented positively on the activity programme. The service has exceeded the standard around provision of the activities programme. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan were evaluated at least six monthly or earlier if there is a change in health status. There was at least a three monthly review by the GP. Not all changes in health status were documented and followed up. Reassessments have been completed using InterRAI LTCF in the files sampled for residents who have had a significant change in health status. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected (for two residents with weight loss), the service did not always respond by initiating changes to the care plan (link 1.3.5.2). |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | The service facilitates access with other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident’s condition had changed and the resident was reassessed.  |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility has two floors. On the first floor, there are 22 certified retirement village apartments. On the ground floor, there are 16 certified retirement village apartments, 30 rest home beds, 47 hospital (including13 dual-purpose beds [verified at audit] in the hospital wing), and including one shared/double room in the hospital area. The dual-purpose beds have adequate space to manoeuvre care equipment for both hospital and rest home level care. All rooms have an ensuite. There is a maintenance manager employed to coordinate the reactive and planned maintenance programme. The building has a current building warrant of fitness that expires 4 August 2017. All medical and electrical equipment has been serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. There is sufficient equipment to cater for the requirements of the residents in the dual-purpose wings and for hospital care residents.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All bedrooms have ensuites. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.  |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | All resident’s rooms (including the 13 reconfigured hospital beds into dual-purpose beds) are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for relaxation, dining and for entertainment. There are separate lounge and dining areas in each unit. All lounges and dining rooms are easy to access and can accommodate the equipment required for the residents. There is a large activities room located off the main reception area. Other lounge areas and seating nooks are available for those residents wishing for a quieter area for visitors or reading. Activities occur in the large activities room and throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. All the communal areas and the wide corridors have handrails. Residents were seen to be moving freely both with and without assistance throughout the audit and all residents interviewed report they can move around the facility and staff assist them if required. There is adequate dining and lounge space in the hospital area to cater for the recreational needs of the residents in the dual-purpose room in the hospital wing. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are dedicated cleaning staff rostered on seven days per week. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.There are dedicated laundry staff rostered on seven days per week. All laundry is completed on site in an appropriately appointed laundry. Residents interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. All registered nurses hold a current first aid certificate. There are call bells in the residents’ rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.  |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The Wood Lifecare has transitioned to the Arvida group infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support and supervision from the clinical manager and other members of the infection control team. Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Arvida infection control programme has been reviewed annually.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse is the designated infection control (IC) coordinator. The infection control coordinator receives supervision and support from the clinical manager. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team have external support from the Arvida Group head office and the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The Wood Lifecare has just transitioned to the Arvida group infection control policies and procedures. The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator attends the Arvida Group infection control training and is provided with education and updates through this forum. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | Infection surveillance is an integral part of the infection control programme and is described in The Wood infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the village manager and head office staff. There have been no outbreaks since the last audit.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were three residents with four restraints (three bedrails and one lap belt) and two residents using an enabler (bedrails) during the audit. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on restraint minimisation and management of challenging behaviour has been provided. Restraint has been discussed as part of quality meetings.  |
| Standard 2.2.1: Restraint approval and processesServices maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.  | FA | The clinical manager is the designated restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the three restraint and two enabler files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.  |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | Assessments identify the specific interventions or strategies trialled before implementing restraint. Approved restraints are documented.  Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator.  The use of restraint is linked to the residents’ care plans.  Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident.  A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.  |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. The service has a restraint and enablers register, which is updated each month. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.  |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.7Advance directives that are made available to service providers are acted on where valid. | PA Low | Advanced directive and resuscitation decision forms are available. The medical officer discusses the residents’ wishes and documents the outcome of this discussion. Not all sections of the advanced directives and resuscitation forms were fully completed in the files sampled.  | Nine of nine files reviewed (four rest home and five hospital) did not have all sections of the advanced directive and resuscitation decision forms fully completed. Not all forms reviewed had been signed correctly and did not consistently evidence discussion with family and/or EPOA. | Ensure advance directives and resuscitation decision forms are fully completed and evidence (where appropriate) discussion with family and/or EPOA.90 days |
| Criterion 1.2.4.3The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Incident reports reviewed evidenced that assessment and clinical care had been provided following an adverse event. Registered nurses assess residents following an adverse event. Neurological recordings had been commenced but not fully completed for two incident forms in the sample.  | Neurological assessments following unwitnessed falls were not consistently documented for two rest home residents (including the rest home tracer). | Ensure that neurological observations are completed, as required by the organisational policy, for all residents following an unwitnessed fall.60 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Negligible | Five of the thirteen registered nurses employed are interRAI trained. Registered nurse turnover and the inability to access sufficient interRAI training have meant that contractual obligations have not been met around interRAI requirements.  | Some residents admitted since 1 January 2016 or with assessments reviewed since this time have not had interRAI assessments completed. This is due to the resignation of trained interRAI assessors which the provider has taken steps to replace. However the scheduling of training for the new staff and other existing staff, which is beyond the control of the provider, has led to a delay in the carrying out of interRAI assessments.” | Access interRAI training for staff when this is available to ensure interRAI contractual obligations can be met.365 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The registered nurse is responsible for the development of the care plan. Short-term care plans were in use for changes in health conditions. Care plan interventions did not always document interventions to meet residents’ assessed needs. Interventions were not fully documented.  | Interventions were not documented in sufficient detail to guide care staff in the provision of care to residents for:I) Five hospital residents (one with an indwelling catheter, end of life care for residents who were palliative, vertigo, vestibular dysfunction and Parkinson’s disease); ii) Two hospital residents with pressure Injuries (one hospital tracer);iii) Two rest home residents with short-term memory loss;iv) Two hospital residents with aggressive behaviours; andv) The Tikanga practices for a resident who identified as Māori. vi) The care plan was not updated for two hospital residents with a significant weight loss. | Ensure that care plan interventions are documented for all care needs. 60 days |

# Specific results for criterion where a continuous improvement has been recorded

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

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.3.10.2Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives. | CI | The service actively works with the multidisciplinary team the resident and the family to rehabilitate residents to transition back to the community and be discharged into their own homes. Once the resident is ready to be discharged home the service develops a discharge plan in association with the resident, their family and the community support services.  | The service actively works alongside the resident and their family to establish a rehabilitative focus to promote independence. This is supported by input from the multi-disciplinary team with a focus on assisting the resident to meet their goals. The care staff and registered nurses interviewed, advised that they are involved in all aspects of care planning and understand that their role is to provide support in a way that focuses on rehabilitation. This approach has resulted in six hospital residents in the past 12 months being transitioned to rest home level care and then safely transferred home, and three residents transitioned from hospital level care to rest home level care. One hospital resident who recently transitioned home was interviewed and advised that her discharge was well co-ordinated and the supports arranged prior to her discharge were very through. She reported she was very happy to be back in her own home. |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The diversional therapists have increased the opportunities for community engagement in their programme in order to improve the overall wellbeing and feeling of worth amongst the residents. The service has actively sort to expand the activities offered and to create meaningful engagement for the residents.  | The Woods has intentionally increased the opportunity for intergenerational engagement by facilitating regular visits from the local primary school the local pre-school and an English language school. These visits are structured so that the residents and the children can share some time in the large communal lounge participating in one-on-one activities. The residents interviewed advised that they really look forward to this contact with the younger generation. The programme has also responded to the request from the residents for more activities that would be of interest to the men. Overall attendance at the men’s group has increased by 68% since the start of the year. Special targeted activities have been provided, such as the programme that focuses on sensory capacity for the hospital residents, music therapy and aromatherapy. There has been a 30% increase in attendance at activities over the past 6 months. The residents and families interviewed spoke very highly of the activities programme.  |
| Criterion 3.5.7Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | The service reviewed the surveillance data in the first six months of the year and noted an increase in the incidence of eye infections in the hospital residents. The infection control team implemented a strategy to reduce the incidence of eye infections in this group.  | The service noted an increase in eye infections in the hospital area and introduced a project to reduce the incidents of eye infections. The care givers were given specific training on eye care and individualised eye care kits were introduced. Management strategies were put in place to reduce the incidence of flying insects and inactive residents were provided with insect nets. The incidence of eye infections reduced from 4 in May 2016 to 0 in June, July and August 2016. |

End of the report.