

Village At The Park Care Limited - Village At The Park

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](#).

The specifics of this audit included:

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| Legal entity: | Village at The Park Care Limited |
| Premises audited: | Village At The Park |
| 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: 23 January 2019 End date: 24 January 2019 |
| 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: | 81 |

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

| Indicator | Description | Definition |
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| | 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

Village at the Park is part of the Arvida Group. The service provides hospital (geriatric and medical), rest home and dementia level care for up to 92 residents including rest home level care for up to 17 residents in serviced apartments. On the day of the audit, there were 81 residents.

This certification audit was conducted against the relevant Health and Disability Services Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff, nurse practitioner, and general practitioner.

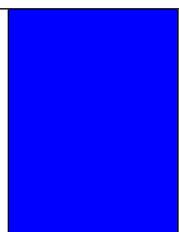
The Village Manager has been in the role since October 2018 and has 14 years health management experience. The Village Manager is supported by a Clinical Lead (Assistant Manager) who has been in the role for 2 years. The managers are supported by three-unit care coordinators.

There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisation's quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

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

The service has been awarded continuous improvement ratings around good practice, community involvement, quality improvements and activities.

Consumer rights

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| 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. |  | All standards applicable to this service fully attained with some standards exceeded. |
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Staff strive 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). The service promotes the attitude of living well (wellness) and introduction of the household model. 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. |  | Standards applicable to this service fully attained. |
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Village at the Park has a current business plan and a quality assurance and risk management programme that outlines objectives for the year. Quality projects are implemented. Quality data is reported to the quality improvement meetings and other staff meetings. There is an implemented annual internal audit calendar schedule. Residents and relatives are provided the opportunity

to feedback on service delivery issues at resident meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education plan and online training modules are being completed as per schedule. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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| <p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p> | | <p>All standards applicable to this service fully attained with some standards exceeded.</p> |
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There is an admission package available that provides information on the services and the three levels of care. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in electronic resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses, enrolled nurses and senior caregivers responsible for administration of medicines complete annual education and medication competencies. The electronic medication charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The diversional therapist and activity coordinators provide and implement an interesting and varied activity programme for each level of care. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritional snacks available 24 hours.

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. |
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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The buildings hold a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. All resident rooms are single and have ensembles. Communal toilets have privacy locks. Rooms are personalised. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is a staff member on duty at all times with 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. |
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Village at the Park has restraint minimisation and safe practice policies and procedures in place. At the time of the audit, there were six residents with restraints, and no residents using enablers. The hospital care coordinator is the designated restraint

coordinator. Assessed risks are documented in care plans. Ongoing restraint assessments, monitoring and evaluation occurs. The service and organisation regularly review restraint use and strive to minimise the use of restraint. Staff receive training around restraint minimisation and enablers.

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. | | Standards applicable to this service fully attained. |
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. 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) |
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| Standards | 3 | 47 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 4 | 97 | 0 | 0 | 0 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with sixteen care staff (seven caregivers, three care coordinators, three registered nurse (RN), two diversional therapists and one activity therapist) confirm their familiarity with the Code. Interviews with seven residents (three rest home and four hospital) and nine families (five hospital and four dementia care) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff, unit and quality improvement meetings. Staff have received training on the Code, last occurring in September and November 2018.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p> | FA | <p>Informed consent processes were discussed with residents and families on admission. Admission agreements sighted for the nine resident files reviewed (three dementia, two rest home and four hospital level of care residents) contained a permission granted section that included name on door, photographs and medical care. Specific consents are available for procedures such as influenza vaccine.</p> <p>Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care.</p> <p>Enduring power of attorney (EPOA) evidence is filed in the residents' electronic charts. The EPOAs had been activated in the three dementia care resident files reviewed.</p> |

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| give informed consent. | | Advance care plans are completed as part of the care plans where the resident was deemed to be competent. Where residents were deemed incompetent to make a resuscitation decision, the GP had made a medically indicated resuscitation decision. There was documented evidence of discussion with the family. Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives. |
| Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff have received training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack/handbook provided to residents/family 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 Resources Consumers are able to maintain links with their family/whānau and their community. | CI | Residents are encouraged to be involved in community activities and maintain family and friends' networks. There has been a focus on inter-generational partnerships with community agencies which have included visiting pre-school and schoolchildren. On interview, staff stated that residents are encouraged to build and maintain relationships. Residents and relatives interviewed confirmed that relative/family visiting could occur at any time. The service is proactive in implementing community involvement. |
| 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 and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. Twelve complaints (from 2018 to year to date) are documented on the complaint register. The complaints reviewed have been managed appropriately with acknowledgement, investigations and responses recorded. Residents and family members advised that they are aware of the complaints procedure and how to access forms. The service is proactive around managing complaints and learning from them (link CI 1.2.3.5). |
| Standard 1.1.2: Consumer | FA | There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the |

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| <p>Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | | <p>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, clinical lead or care coordinators discuss the information pack with the resident and the family/whānau. The information pack includes a copy of the Code.</p> <p>All seven residents and nine relatives interviewed report the residents' rights are being upheld by the service</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>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. Adequate space is available for discussions of a private nature.</p> <p>All of the residents interviewed confirmed that their privacy is being respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect. Advised that any suspected instances of abuse or neglect by staff are dealt with in a prompt manner by the village manager and clinical lead.</p> <p>There is a policy that describes spiritual care. Church services are conducted regularly. Residents interviewed indicated that resident's spiritual needs are being met when required.</p> <p>Electronic care plans capture specific individualised values and beliefs and wishes of each resident.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | FA | <p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan in place. There was one resident that identified as Māori at the time of the audit. The file of the resident identified as Māori was reviewed and included a specific Māori health care plan. The service has established links with the local iwi and the Tenth Trust have joint ownership in the land. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process. Discussions with the caregivers confirm that they are aware of the need to respond to cultural differences.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive</p> | FA | <p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. The service identifies the residents' personal needs, values and beliefs, and desires from the time of admission and incorporates this information into the residents' care plan on eCase. The resident (if appropriate) and/or their family/whānau are asked to consult on meeting their cultural values and beliefs</p> |

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| culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | | during the six-monthly case conference. Staff receive training on cultural awareness. Cultural diversity in aging is also covered as part of the induction training programme. Interdenominational church services are held and there is a small chapel on-site. |
| Standard 1.1.7: Discrimination Consumers 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 Practice Consumers receive services of an appropriate standard. | CI | <p>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. Arvida is operationalising their vision 'to transform the ageing experience' within the care communities through the introduction of the wellness/household model. This is up and running at Village at the Park.</p> <p>Advised that when the ownership of the Village transitioned over to Arvida, the Spark of Life programme changed to the Attitude of Living Well, which aligned to Arvida's five pillars of Moving Well, Eating Well, Thinking Well, Resting Well and Engaging Well. With the focus on building relationships with residents, not just completing a series of tasks, they can positively influence their lives and wellbeing. The wellness/household model focuses on the relationship between the care team and the resident as partners in the pursuit of a rich and meaningful life. Residents are supported within the care communities by decentralised self-led teams of employees that together create home, nurture relationships, determine their own lives and build community. Residents are encouraged and supported to create a comfortable living space suited to their particular needs and personal tastes. There service has made a number of improvement projects since previous audit.</p> |
| Standard 1.1.9: Communication Service providers communicate effectively | 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 alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Sixteen incident/accidents (from December 2018 across all |

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| <p>with consumers and provide an environment conducive to effective communication.</p> | | <p>areas) on the eCase incident register had documented evidence of family notification. Progress notes also identified family communication. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. Regular family newsletters are provided from across all areas. Interpreter services are available as required.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>Village at the Park is part of the Arvida Group. The service provides hospital (geriatric and medical), rest home and dementia level care for up to 92 residents including rest home level care for up to 17 residents in serviced apartments. On the day of the audit, there were 81 residents in total. In the hospital of 42 beds, there is 36 hospital residents and 4 rest home residents. There were 32 residents across the two dementia units (15 of 15 residents in Aroha unit and 17 of 18 residents in Manaaki unit) and 9 rest home residents across the 17 certified serviced apartments. All except two residents in the hospital (under ACC contracts) were under the aged residential related care (ARRC) agreement.</p> <p>The village manager has been in the role since October 2018. She has 14 years health management experience with a number of years with the DHB. The village manager is a clinical lead (assistant manager) who has been in the role for two years. The managers are supported by three unit care coordinators (two RNs and one EN); one in each of the three units (hospital, rest home and dementia care), all of who are qualified and experienced for the roles.</p> <p>The village managers' report to the Arvida senior management team on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Village at the Park has a business plan 2018/2019 and a quality and risk management programme. There are annual quality objectives that include three dimensions. Achievement to meeting objectives is reviewed annually. The 2018 objectives are to be reviewed at the next quality meeting.</p> <p>The village manager and clinical lead have completed in excess of eight hours of professional development in the past twelve months.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of</p> | <p>FA</p> | <p>In the absence of the village manager, clinical lead (assistant manager) is in charge. Support is provided by the unit care coordinators and national quality manager.</p> |

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| <p>the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | | |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>There is a quality and risk management system in place at Village at the Park which is designed to monitor contractual and standards compliance. There is a 2019 business/strategic plan that includes quality goals and risk management plans. There is a Quality & Risk management plan 2019 that includes quality objectives for the group. The quality and risk management system support improved resident outcomes and identifies where improvement is needed. The management team is responsible for providing oversight of the quality and risk management system on-site, which is also monitored at an organisational level. Each unit implements internal audits in each of their units. Interviews with staff confirmed that there is discussion about quality data at various facility meetings. Arvida Group policies are reviewed at least every two years across the group. Head office upload the new/updated policies on the Arvida intranet for staff to read. The service policies and processes meet relevant standards and links to their electronic system.</p> <p>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. There are various meetings across the village including (but not limited to) monthly quality meetings, weekly clinical meetings and one-three-monthly unit (household) meetings. Quality data is shared is reported through all relevant meetings. Corrective actions identified are shared with staff through meetings, message board on eCase and reports.</p> <p>The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. The monthly manager reports include complaints.</p> <p>Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. A resident/relative satisfaction survey was completed in March 2018. Corrective actions have been established in areas where improvements were identified. The net promoter score between the 2017 and 2018 survey increased from 42% to 51%. Resident/family meetings occur monthly in households and the results of the satisfaction survey and other quality data has been discussed at the meeting.</p> <p>The service has a health and safety management system that is regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the Health and Safety Committee that meets monthly. The village manager is the health and safety officer and has completed specific health and safety training in her role. There are trained H&S reps in each household.</p> |

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| | | Hazard identification forms and an up-to-date hazard register is in place which was last reviewed at the H & S meeting. Falls prevention strategies are implemented including identifying residents at higher risk of falling and the identification of interventions on a case-by-case basis to minimise future falls. |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>There is an accidents and incidents reporting policy. The clinical nurse lead investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality, staff and clinical meetings including actions to minimise recurrence. An RN conducts clinical follow up of residents. Sixteen incident forms reviewed demonstrated that appropriate clinical follow up and investigation occurred following incidents. A post fall review was completed for all the incident related to falls.</p> <p>Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one serious incident reported to Worksafe in 2019 and three section 31 incident notifications regarding pressure injuries in 2018. Public Health were notified of an influenza outbreak July 2017 and gastro outbreaks October 2017 and June/August 2018.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>There are human resource management policies in place. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. Ten staff files were reviewed (two care coordinators, four caregivers, three RNs and one diversional therapist). Reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed including one- three-month appraisals for new staff. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Induction training days are completed, and staff are monitored to ensure they have completed induction competencies. The orientation programme includes video and e-learning on all aspects of the facilities procedures. Completed orientation competencies were in files and staff described the orientation programme.</p> <p>The in-service education programme for 2018 year to date has been completed. Arvida has introduced an online training programme for staff. Discussions with the caregivers and RNs confirmed that online training through Altura is available and is being completed. Eight hours of staff development or in-service education has been provided annually. There is a staff educator who works in that role three days a week. She is also a Careerforce assessor. A register of staff attendance is maintained and includes completed competencies.</p> <p>There are eleven RNs and eight have completed interRAI training. Registered nurses have appropriate training and competencies to meet the medical needs of residents, including palliative care. There are 23 caregivers who work routinely in the dementia unit and 14 have completed the dementia standards. Three caregivers are in the process of completing and have all commenced work within the last 18 months. Six</p> |

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| | | caregivers are yet to commence and all six are new to the service. The Arvida group hosts two conferences per year for village managers and clinical managers to promote the updating of skills and knowledge. |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>There is a staff rationale and skill mix policy. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 114 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager and clinical nurse lead work 40 hours per week, Monday to Friday and are available on-call after hours. In addition, there are three care coordinators (hospital, rest home and dementia care). There is at least one RN on at any one time. Interviews with staff, residents and family members confirm there are sufficient staff to meet the needs of residents.</p> <p>In the hospital unit, there are 36 hospital and 4 rest home residents. The hospital care coordinator (RN) is supported by two RNs (one may be an EN) on the morning shift, an RN on afternoon shifts and one RN on night duty. There are eight HCAs rostered on the morning (four long shifts and four short shifts), seven HCAs on the afternoon shift (four long shifts and three short shifts) and two HCAs on night duty.</p> <p>In the rest home (also LTO's), there are nine rest home residents. The rest home care coordinator (EN) is supported a caregiver on morning shift, two caregivers on afternoon shift (one long and one short shift) and one caregiver at night. The clinical care lead provides RN support into the rest home.</p> <p>In the dementia care unit, there are 32 of 33 residents across 2 separate units. The dementia care coordinator (RN) works 0800 – 1600 across five days. She is supported by another RN five days a week from 0700 – 1500.</p> <p>In Aroha there are 15 beds. There are two caregivers rostered on the morning shift, three on the afternoon shift (including one floater between the two units) and one HCA on night duty. In Manaaki unit there are 18 rooms. There are three caregivers rostered on the morning shift, three on the afternoon shift (including one floater between the two units) and one HCA on night duty. There are three rostered diversional therapists across the dementia units to cover seven days.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p> | FA | <p>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 and password protected on computers. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible and dated by the relevant HCA or RN. Electronic records are integrated and include input from GPs and allied health.</p> |

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| accessible when required. | | |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services and rest home, hospital and dementia level of care are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed (for long-term residents) align with all contractual requirements. Exclusions from the service are included in the admission agreement.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | FA | <p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | FA | <p>There are policies and procedures in place for safe medicine management. Staff who administer medications (RNs, enrolled nurses and senior caregivers) have been assessed for competency on an annual basis and complete annual medication education. Registered nurses have completed syringe driver training. Medications are stored safely in each unit. All medication (blister packs) are checked on delivery against the medication chart with documented evidence on the electronic medication charts. As required medications had expiry dates checked regularly. The medication fridges are checked daily and are maintained within the acceptable temperature range. All eye drops sighted in the medication trolleys were dated on opening. There is a bulk supply order for hospital level residents. There were no residents self-medicating on the day of audit.</p> <p>Eighteen medication charts reviewed on the electronic medication system met prescribing requirements. The medication charts had been reviewed three-monthly. Medication competent staff enter the effectiveness of 'as required' medications into the electronic system and in the electronic progress notes.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual</p> | FA | <p>The meals and baking are prepared and cooked on-site. The kitchen manager oversees the service and is supported by cooks, assistant cooks and kitchen assistants (morning and afternoon). Food services staff have completed orientation on induction and ongoing training. There is a four-weekly /summer menu in place that has been reviewed by the company dietitian. The menu provides a vegetarian option and texture</p> |

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| <p>food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | | <p>modified meals. Buffet breakfasts are served in the households and there is a weekly cooked breakfast. The main meal is at dinner time. Meals are delivered in dishes in the hot boxes and delivered to the unit bain marie where meals are served by kitchen staff and care staff. Resident dislikes/allergies are accommodated, and alternative foods offered. The chef receives resident dietary profiles and notified of any dietary changes including weight loss. Smoothies and high calorie foods are provided for any residents identified with weight loss. There are additional foods and nutritious snacks available for residents in the dementia are unit.</p> <p>The food control plan has been verified and expires 14 June 2019. Freezer, fridge and end cooked, re-heating (as required), cooling and serving temperatures are taken and recorded. The dishwasher rinse and wash temperatures are taken and recorded. All perishable foods and dry goods were date labelled. Chilled goods are temperature checked on delivery. The chemical provider services the dishwasher monthly. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>The kitchen manager receives feedback on the meals through the resident meetings and verbal feedback and surveys. Residents and relatives interviewed spoke positively about the choices and meals provided.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | <p>FA</p> | <p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | <p>FA</p> | <p>The RN completes an interim care plan on admission including relevant risk assessment tools. Risk assessments are completely six- monthly or earlier due to health changes. InterRAI assessments and long-term care plans were completed within the required timeframes and reflected in the needs and supports documented in the care plans. Other information is gathered from discharge summaries, medical notes, allied health notes and consultation with resident/relative or significant others and included in the long-term care plans.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery</p> | <p>FA</p> | <p>Resident care plans reviewed on the resident electronic system were resident focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. The eCase programme identifies interventions and supports that cover a comprehensive set of goals including managing medical</p> |

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| <p>plans are consumer focused, integrated, and promote continuity of service delivery.</p> | | <p>needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or recent fall. Any short-term changes are made to the electronic care plan using the fast edit option.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian, speech language therapist, audiology, and community mental health services.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit, NP visit or nurse specialist consultant. Care plans reflect the required health monitoring interventions for individual residents. Computers in each nurse's station allows caregivers the opportunity to sign a task that has been completed, (e.g., resident turns, bowel chart, behaviour chart restraint monitoring) on their worklog. Monitoring charts are well utilised. The electronic care plans are updated to reflect acute changes in health. Resident falls are reported electronically and recorded in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family are notified of all changes to health as evidenced in the electronic progress notes.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. There is access to a continence specialist as required.</p> <p>Wound assessments, wound management plans and photos were reviewed on eCase for eleven residents in the hospital with wounds (including five residents with pressure injuries). One resident (for palliative care) had four pressure injuries (one stage I, two stage II and one unstageable). There were four residents, all with stage II pressure injuries (three facility acquired and one hospital acquired). There were six residents with wounds in the dementia care unit (five skin tears and one facility acquired pressure injury of the heel that has become stage III). Chronic wounds and pressure injuries were linked to the care plans. There were documented pressure injury prevention and management plans including repositioning charts, air alternating mattresses, redistributing cushions and booties. The wound district nurse has been involved in the management of complex or non-healing wounds and pressure injuries. When wounds are due for a change of dressing a prompt activity is scheduled on the RN daily work log. Caregivers document changes of position on eCase.</p> <p>Monitoring charts are completed on the electronic system such as pain, observations, behaviour, weight, food and fluids, neurological observations and re-positioning. Work logs for the caregivers and RNs record cares and monitoring is completed as outlined in the care plans.</p> |

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| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>CI</p> | <p>The service employs a qualified diversional therapist (DT) and a team of five activity coordinators to coordinate and implement the activity programme across the seven days a week in the hospital and dementia care households. In the rest home there is an activity coordinator Monday to Friday for three hours a day. One activity coordinator covers the weekends for both dementia households. Activity coordinators across the dementia units have completed the dementia standards. The DT is based in the hospital households from Sunday to Thursday. Care staff coordinate activities for residents as per the programme on the activity persons days off. The activity programme is also written in Māori, Chinese and Greek. The activity team communicate with families through the service Facebook page, skype and video calls to families.</p> <p>The programme reflects activities that focus on the five pillars of engaging well such as: art and crafts with children; Japanese theme club; SPCA visit; cooking club (engaging well),\; cooked breakfasts; coffee club (eating well); crafts; news and views; reminiscing (thinking well); morning exercises; carpet bowls; chair line dancing (moving well); movies; hairdresser; sensory activities; and pampering (resting well). Each household has activity programme and there are many integrated activities including church services, entertainment, music appreciation, games club and guest speakers. Community visitors including pet therapy, dance groups, pre-schoolers and school I children visit regularly. Activities provided meet the cognitive and physical abilities and preferences of the residents. One on one activities such as individual walks, newspaper reading, and hand massage occur for residents who choose not to be involved in group activities. The DT has initiated a sensory room which is well utilised by all residents for an individual sensory experience. Activities in the dementia unit are flexible and are meaningful to the residents including garden walks, music, cooking and reminiscing. There is entertainment in all units on a regular basis and van outings to places of interest and scenic drives for all residents.</p> <p>A resident leisure profile is completed soon after admission. Individual leisure plans were seen in resident electronic files. The DT and activity coordinators are involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through monthly resident meetings. The residents and relatives interviewed were happy with the activities provided.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>All interim care plans for long-term residents were evaluated by the RN within three weeks of admission and changes documented in the case conference notes which also evidence resident/relative input into the review. Long-term care plans have been evaluated by the RN six-monthly or earlier for any health changes for the long-term resident files reviewed. Family are invited to attend the multidisciplinary review meeting and case conference notes are kept. Written evaluations reviewed identified if the resident goals had been met or unmet. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p> |

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| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>There are policies regarding chemical safety and waste disposal. There is a main chemical store room where chemicals are stored. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas in each unit. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. Gloves and aprons are available for staff and they were observed to be wearing these as they carried out their duties on the day of audit. There are sluice rooms in each unit with appropriate personal protective clothing.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>There are two buildings. One building is the community centre where the serviced apartments and independent living apartments are located. The care facility (hospital and dementia care units) are located directly opposite the community centre. There is an internal corridor that links the buildings to provide access for staff, meals trolleys, laundry services etc. The buildings have a current warrant of fitness that expires 16 March 2019.</p> <p>There is a maintenance person who works full-time, is a health and safety representative and has completed work safe courses. Maintenance requests are registered on the electronic system and a maintenance request book is also available at the main reception. Daily and planned maintenance worklogs are completed, signed off and reported to the village manager. Essential contractors are available 24 hours. The maintenance person has been approved to test and tag electrical equipment. Hoists and resident equipment have been checked and calibrated. Hot water temperatures in resident areas are randomly checked each</p> |

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| | | <p>month with correctives actions recorded for any temperatures over 45 degrees Celsius.</p> <p>The corridors are wide with handrails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the communal areas with mobility aids. A gardening team maintain the grounds and gardens. The café courtyard and dementia unit courtyard have been upgraded. All outdoor areas have seating and shade. There is safe access to all external communal areas.</p> <p>The dementia unit garden is safely fenced. Doors from the dining and lounge areas from both households open out onto the gardens with a walking pathway between the households. There are raised gardens and a shed with brooms, watering can and other safe gardening tools.</p> <p>Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>All serviced apartments for rest home level of care (in the community centre) have full ensuites. All resident rooms in the hospital and dementia care unit have full ensuites. Fixtures, fittings and flooring are appropriate and made of materials for ease of cleaning. There is sufficient space in toilet and shower areas to accommodate shower chairs if appropriate. There are communal toilets located near communal areas with privacy signs. Residents interviewed confirm care staff respect their privacy when attending to their hygiene cares.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | <p>All rooms are single. There is sufficient space in all resident rooms to allow care to be provided and for the safe use of mobility equipment and hoists as required. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p> |
| <p>Standard 1.4.5: Communal</p> | FA | <p>Each household in the hospital and dementia care unit have a dining and lounge area. There are smaller</p> |

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| <p>Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | | <p>lounges and seating alcoves which residents and visitors can use. There is a café with doors that open out onto a courtyard. Activities occur in the larger areas and the smaller areas are spaces for residents who prefer quieter activities.</p> <p>The rest home residents in the serviced apartments join other residents in the community centre dining room and can access other communal areas in the community centre or care centre. There is a sensory room in the care centre main corridor that is available to all residents.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | FA | <p>The laundry and cleaning services are managed by the residential services manager. Currently only personal clothing is being laundered on-site due to re-construction of the laundry and installation of new equipment. The area under re-construction is cordoned off and laundry staff have access to the large domestic washing machine and dryer for personal clothing. All laundry is picked up and delivered daily by a commercial laundry. The laundry is divided into a “dirty” and “clean” area. Sufficient linen and towels were available in the units.</p> <p>There are dedicated staff to complete cleaning duties over seven days a week. Cleaning trolleys were well equipped and are stored in locked rooms when not in use. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system and the chemical provider who also monitors the effectiveness of chemicals and the laundry/cleaning processes.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | FA | <p>There is an emergency/disaster management plan in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring November 2018. There is an approved NZ Fire Service evacuation scheme in place dated 29 November 2016. There are monthly checks of all facility fire equipment. Fire training and security situations are part of orientation of new staff and is ongoing. There is always at least one staff member with a current first aid certificate on duty.</p> <p>There is civil defence equipment and food supplies held in each unit. A barbeque is available for alternative cooking. There is an external water tank (25,000 litres). Short-term backup power for emergency lighting is in place for up to three hours. The service has an agreement with electrical authorities for the priority provision for power and gas supply.</p> <p>There are call bells in the residents’ rooms, ensuites, communal toilets and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The facility is secured at night.</p> |

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| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All bedrooms and communal areas have ample natural light and ventilation, with some resident rooms and communal rooms opening out onto the internal courtyards. There is a mix of radiator heating and heat pumps. Contractors have been servicing and checking the heating systems. Resident meeting minutes confirmed the residents had been notified there could be fluctuations in temperatures during the maintenance work.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The clinical lead is the infection control coordinator with responsibility of overseeing infection control management for the facility. There is a job description that outlines the responsibility of the role. The infection control coordinator provides a monthly report to the quality meeting, staff meeting and clinical meeting and a bi-monthly report to head office. The infection control programme is reviewed annually in consultation with the Infection Control Committee. The last review was January 2019.</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the annual influenza vaccine (95% rate 2018). Two gastric outbreaks were reported May and July 2018. A summary report (August 2018) was completed that included a summary of the management plan, evaluation and change of practice.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | <p>The infection control coordinator (clinical lead) has attended Bug control training days and IC meetings for aged care providers. The Infection Control Committee comprise of representatives from all areas of the service. There is a signed job description for the infection control coordinator. The committee meets monthly and the meeting minutes are available in the staff room which staff read and sign. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. Advice and support are readily available from expertise within the organisation, infection control nurse specialist at the DHB, laboratory technician, nurse practitioner and GPs.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the</p> | FA | <p>There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes responsibilities of the infection control team and training and education of staff. The policies have been reviewed by the Arvida Group at head office.</p> |

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| <p>prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | | |
| <p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>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 on orientation and annually that includes infection control induction, hand hygiene audits and infection control competencies. Regular IC training also occurs through the Altura online training programme. Resident education occurs as part of daily cares.</p> |
| <p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on signs, symptoms and definition of infection. Infections are entered into the infection register on the electronic database. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and analysed for trends monthly and annually. Infection control surveillance is discussed at all meetings. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives benchmarking feedback from head office. Comprehensive reports have been completed following outbreaks. There is a MRO register maintained.</p> |
| <p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit, there were six residents with restraints, and no residents using enablers. Enabler use is voluntary and a consent form available should enablers be requested. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The restraint coordinator described how one resident with a recent enabler bedrail had requested it to be removed and the resident now has no enablers. Staff receive training around restraint minimisation and enablers and challenging behaviour.</p> |

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| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services 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.</p> | FA | <p>The hospital care coordinator is the designated restraint coordinator. There are clear lines of accountability and responsibilities including consent and assessment processes. Assessment and approval process for restraint use included the restraint coordinator, RNs, resident/or representative and GP.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA | <p>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. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the two restraint files reviewed (both residents required a lap belt intermittently during the day and a bedrail at night), assessments and consents were completed.</p> |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | FA | <p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. An assessment form/process is completed for all restraints which link to interventions on eCase. The two restraint files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring was documented at least two-hourly on eCase. The service has a restraint and enablers register, which was up to date.</p> |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p> | FA | <p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are completed by the restraint coordinator at least three-monthly or earlier if required. Each resident is also reviewed at weekly clinical meetings and three-monthly at GP medical reviews. A review of two restraint files identified that evaluations were up to date.</p> |

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| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | <p>FA</p> | <p>Individual approved restraint is reviewed at least three-monthly as part of the medical review with the resident/family/whānau, as appropriate. Restraint is discussed at the weekly clinical meetings. A monthly restraint/enabler report is completed. Restraint usage is monitored regularly by the restraint coordinator three-monthly and through case conference with families six-monthly. Restraint and enabler use internal audit was last completed July 2018. The Restraint Committee meets formally twice-yearly (last met November 2018).</p> |
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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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Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| Criterion 1.1.12.1 Consumers have access to visitors of their choice. | CI | One of the quality goals for Village in the Park is to ‘Grow the involvement of local community at Village at the Park’. There are a number of quality initiatives that have been implemented to meet this goal. | <p>1)There have been intentional links developed with community groups that has strengthened community relationships and given residents a meaningful sense of purpose. An iPlayed programme (intergenerational Programme to Learn, Appreciate, Yield, Engage and Dream) was initiated in consultation with a lead research at Massey University. There is an early childcare centre on-site which has enabled the resident and children to interact (engaging well), without transport (moving well) and participate in intergenerational activities (thinking well). Pre-school children visit four times a week for up to one hour and enjoy activities with the residents including arts and crafts, buddy reading, singing and supervised swimming in the community centre swimming pool. The service received an award for this initiative at the NZACA conference 2018. The DT also received an individual award for “stand out” DT.</p> <p>2)Over the last year the service has actively supported community groups including Spectrum (adolescents with disabilities) who visit weekly and facilitate quiz sessions and conversations with the residents. Over Christmas the residents and students held a craft stall raising funds for Spectrum. A thank you letter was sighted from the Spectrum coordinator.</p> <p>3)A group of dementia care residents attended a six-week series of Yoga classes in</p> |

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| | | | <p>the community provided by Dementia Friends (a sub-branch of Alzheimer's NZ). Residents who attended the classes enjoyed them and were observed to be following instruction. As a result, the care coordinator is planning to incorporate yoga classes into the community centre for all residents to attend as they wish.</p> |
| <p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p> | CI | <p>The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction.</p> | <p>The household divisions reflect Arvida 'Living Well' vision and values of person-centred care, where the emphasis is on building relationships with residents over task orientated care. The care centre has been divided into smaller households. Mary Coleman (Hospital unit) was divided into two households, Kauri Grove and Rata Lane. Household dedicated staff provide continuity of care to residents. This has also been established in the Manaaki and Aroha households of Buchanan (Dementia care). The Living Well model is also working well in the Millard (Rest Home) environment, where residents have been able to remain living as independently as possible, for as long as possible. This model has resulted in household staff becoming very familiar with their residents and has increased accountability for outcomes such as falls prevention, pressure injury prevention and weight loss. Family meetings have been introduced 3x yearly across each area which also includes an education component. Residents have also become involved in recruiting staff on an interview panel in households.</p> <p>The service has also introduced weekly clinical meetings and mentoring by the Clinical lead which has built capability in care coordinators. There is also in-house management and leadership programme to registered and enrolled nurses and level 4 caregivers. Meeting minutes evidence action of clinical issues and management of deteriorating residents in a timely manner with mentoring and support of staff. The 2018 resident/relative satisfaction survey identifies and increase from 2017 of satisfaction around clinical care to 83%.</p> |
| <p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management</p> | CI | <p>There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six-monthly or annually as designated by the internal auditing programme</p> | <p>The service has taken a pro-active response to all complaints so that staff can learn from them. All complaints are investigated. An annual complaint summary for 2018 was completed that included whether they were substantiated, partially substantiated and unsubstantiated. A root cause analysis was completed for each complaint. Corrective actions were established including (but not limited to): having the complainant share 'how they feel' at household meetings; leadership and management coaching to RNs and senior caregivers; specific Altura learning modules were promoted for staff; and increased staffing in the hospital, including an experienced NZ</p> |

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| system. | | <p>schedule. Key components of the service delivery link to meetings so that opportunities for improvement can be identified and implemented. The clinical lead implements a comprehensive monthly report that includes feedback on adverse events, infection surveillance, complaints and internal audit feedback.</p> | <p>RN as a role model for internationally-trained nurses. The proactive approach to learning from complaints and sharing these with staff identified a decrease in the number of complaints in the second-half of 2018.</p> |
| <p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | CI | <p>The DT researched the benefits of sensory aspects on residents with cognitive loss. A sensory room was created for the enjoyment of all residents with positive effects on resident wellbeing.</p> | <p>Following research into the use of sensory rooms, the DT initiated a project in August 2018 to create a sensory room within the care centre. The hair salon (when not in use) transforms into a beautiful sensory room with various sensory aspects including soft lighting, scented candles, relaxation music, comfortable relaxation chair with luxurious cover and throws and screen projecting peaceful pictorials such as shorelines with lapping waves and the sound effects of the waves and beach. Residents with cognitive loss are accompanied by a staff member. There is a booking system for all other residents able to use the sensory room independently. Foot spas and hand massages are offered as part of the sensory experience. There is an "experience book" where residents write their comments on the sensory room. Positive comments were sighted in the "experience book" for example "peaceful", "spiritual" and "sense of wellbeing". A formal evaluation/survey identified that all respondents strongly agree the sensory room adds quality to the life of a resident residing in residential care. The DT is gathering information (with consent) to present a research project to the DT society; "a descriptive study on the effects of the sensory room using sensory stimulation to improve the quality of life for residents in residential care". The sensory room was viewed on the day of audit. Resident meeting minutes and resident interviews had very positive comments on the sensory room.</p> |

End of the report.