

# Village At The Park Care Limited - Village At The Park

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Village at the Park Care Limited
<b>Premises audited:</b>	Village At The Park
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 16 March 2021 End date: 17 March 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	76

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

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

### Key to the indicators

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

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

## General overview of the audit

Village at the Park provides hospital and rest home level care for up to 92 residents. On the day of audit there were 76 residents.

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

The service is managed by an experienced village manager who is supported by a clinical manager and three clinical leads. The residents, relatives and the general practitioner interviewed spoke positively about the care and support provided.

The service continues to implement a comprehensive quality and risk management system. Interviews with staff and review of meeting minutes demonstrated a culture of quality improvements for each individual household, and evidence sharing of quality data and results.

This audit identified shortfalls around timeframes and interventions.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Communication with residents and relatives is appropriately managed. Relative notification is well documented in resident files. Interviews with relatives confirmed relatives are regularly updated of residents' condition including any acute changes or incidents. An electronic compliment and complaint register is maintained. There have been no complaints lodged since the previous audit, and several compliments documented.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There are annual organisational and site-specific quality goals for the service that are regularly reviewed. There is a documented quality and risk management system in place. Quality data is collated for accident/incidents, infection control, internal audits, restraint, concerns and complaints and surveys. Incidents and accidents are reported and appropriately managed. Residents and relatives are provided the opportunity to feedback on service delivery issues at resident meetings and via annual satisfaction surveys. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The staff, residents and relatives reported there is sufficient staff rostered to cater for resident needs.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nurses are responsible for each stage of service provision. The assessments and care plans are developed and evaluated in consultation with the resident/family/whānau. The activity programme is varied and appropriate to the level of abilities of the residents. Medications are appropriately managed, stored, and administered with supporting documentation. Medication training and competencies are completed by all staff responsible for administering medicines. Food is prepared on site with individual food preferences, dislikes and dietary requirements assessed by the registered nurses and a dietitian. The residents and relatives were overall satisfied with food services.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service has a current building warrant of fitness. A reactive and preventative maintenance programme is in place. There is adequate room for residents to move freely about the home using mobility aids. Outdoor areas are well maintained, safe and easily accessible for the residents and shade is provided. The outdoor area in the dementia unit is secure and accessible to residents. Staff reported there is adequate equipment for the safe delivery of care.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has policies and procedures to ensure that restraint is a last resort. On the day of the audit there were six residents using restraints and no residents using enablers. Staff receive training in restraint minimisation, and challenging behaviours.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. The service benchmarks infection control data against other villages within the group. There was one suspected outbreak since the previous audit, which was treated as an outbreak, with appropriate notifications made. Test results were negative for influenza and Covid-19.

Covid-19 was well prepared for with organisational policies and procedures and the pandemic plan updated to include Covid-19. Resource folders are easily accessible to staff in each household. Relatives reported communication was maintained through the lockdown periods. Extra training around Covid-19 policies and infection control practices has been provided. Adequate supplies of personal protective equipment were sighted, and each household have isolation kits available.

## 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)
<b>Standards</b>	0	14	0	2	0	0	0
<b>Criteria</b>	0	39	0	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>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 each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. An electronic complaints register is available. There have been no complaints lodged since the previous audit. Residents and relatives interviewed advised that they are aware of the complaints procedure and how to access forms. The management provide an open-door policy and residents and relatives stated they feel comfortable discussing issues with the management and their concerns are dealt with promptly and appropriately.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Four residents (one rest home, and three hospital) interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Ten incident/accidents reviewed had documented evidence of family notification or noted if family did not wish to be informed. Two relatives (dementia) interviewed, confirmed that they are notified of any changes in their family member's health status. Interpreter services are available as required. Clinical staff interviewed (one village manager, one clinical manager, one educator/activities assistant, one hospital clinical leader, three registered nurses (RNs), eight caregivers (wellness partners) and one wellness leader) were fluent when describing instances where relatives would be notified and responsibilities around this.</p>



conducive to effective communication.		
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<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 76 residents in total. In the 42-bed hospital, there were 32 hospital residents and 4 rest home residents. There were 31 residents across the two dementia units (14 of 15 residents in Aroha unit and 17 of 18 residents in Manaaki unit including one resident on a long-term support - chronic health contract) and 9 rest home residents across the 17 certified serviced apartments. All except two rest home residents in the hospital (under ACC contracts) were under the aged residential related care (ARRC) agreement.</p> <p>The village manager (non-clinical) has been in the role since October 2018. She has previous experience in health management with several years with the DHB. The village manager is supported by a clinical manager (RN) who has been in her role for one year and has previous experience in clinical management in aged care. The managers are supported by three clinical leads (one RN and two ENs); one in each of the three units (hospital, rest home and dementia care), all of whom are qualified and experienced for the roles.</p> <p>Arvida has an overall business/strategic plan. The village manager reports to the Arvida senior management team on a variety of operational issues and provides a monthly report. Village at the Park has a business plan 2020/21. The quality and risk management programme is due for review in April 2021. There are annual quality objectives that include three dimensions. Achievement to meeting objectives and quality goals are reviewed on a monthly basis at each quality meeting.</p> <p>The management team reported a high level of registered nurse turnover, largely due to nurses leaving to join the district health board (DHB). There has also been a high turnover of caregivers. The service is actively recruiting to fill the positions with staff completing inductions during the audit.</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><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality</p>	FA	<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 an annual business/strategic plan that includes quality goals and risk management plans for Village at the Park. The village manager and clinical manager are responsible for providing oversight of the quality and risk management system on site, which is also monitored at organisational level. Interviews with staff and meeting minutes confirmed that there is discussion about quality programme progress at the quality, clinical and RN and full staff meetings. Staff household meetings are held which discuss quality data specific to the household. Resident meetings (open to all residents in the service) are held monthly and provide an open forum for residents to provide suggestions for improvement around all aspects of the service.</p>

<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>Data is collected in relation to a variety of activities including restraint/ enabler use, infection control, and the Living Well pillars of care. An internal audit schedule has been completed, and areas of non-compliance identified through quality activities are actioned for improvement. The staff interviewed could describe the quality programme corrective action process.</p> <p>Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The 2020 satisfaction results evidenced overall satisfaction with the service, however, the results were noted to be slightly lower than the previous survey in 2019. Ninety-two percent of respondents were very satisfied with the care staff, down slightly from the 2019 results (96%). Respondents were overall satisfied with the wellness programme with 72% in 2020, down slightly from 87% previously. The manager and clinical manager stated they were comfortable with the comments made.</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 at the monthly meeting. The village manager is part of the Health and Safety committee and has completed specific health and safety training in her role. Electronic hazard identification forms and an up-to-date hazard register is in place which is reviewed at least annually, sooner if there is an incident. 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>
<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>	<p>FA</p>	<p>The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff and household meetings including actions to minimise recurrence. Ten electronic incident forms reviewed for March demonstrated that appropriate clinical follow-up and investigation occurred following incidents. An RN conducts clinical follow up of residents. Neurological observations were documented for unwitnessed falls with a potential for a head injury. Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three section 31 incident notifications required since the last audit (change in clinical manager, stage 3 pressure injury and a resident absconding). There have been no outbreaks since the previous audit.</p>
<p>Standard 1.2.7:</p>	<p>FA</p>	<p>There are human resource management policies in place. The recruitment and staff selection process requires that</p>

<p>Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>relevant checks are completed to validate the individual's qualifications, experience, and veracity. Eight staff files were reviewed (one clinical manager, one clinical lead (RN), one registered nurse, three caregivers one housekeeper and one diversional therapist). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all eight staff files reviewed. 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. The educator oversees completion of competencies and the induction process. Completed orientation is on files and staff described the orientation programme.</p> <p>The in-service education programme for 2020 has been completed and the plan for 2021 is being implemented. Discussions with the educator and caregivers and RNs confirmed that Altura online training is available and implemented by staff. Staff development and in-service education has been provided annually and exceeds the eight hours required. Education sessions are held in alternate staff meetings and via the Altura system. The educator maintains a spreadsheet with training sessions and attendance and a monthly report is completed which include education sessions held and education hours completed. Annual report is also provided to the clinical manager.</p> <p>There are 16 RNs, four RNs including the hospital clinical lead and RN and two ENs have completed interRAI training and three are in the process of completing the training. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the district health board (DHB), hospice and webinars for wound care education sessions.</p> <p>Caregivers are encouraged to complete New Zealand Qualification Authority (NZQA) through Careerforce. Currently there are 15 caregivers with level 2, 18 caregivers with level 3 and five caregivers with level 4 health and wellbeing. There are 19 caregivers currently completing training. There is a total of 29 staff currently working in the dementia unit. Fourteen staff have completed the level 4 dementia standards, seven are currently completing the standards, and a further eight have been recently employed. There are a further 10 caregivers who work in other units who have either level 4 NZQA or have completed the dementia standards who can be called on to work in the unit.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced</p>	<p>FA</p>	<p>Village at the Park has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The service has a total of 125 staff in various roles. Staffing rosters were sighted and there is staff on duty to meet the resident needs. The village manager and clinical manager work 40 hours per week and are available on call after-hours for any operational and clinical concerns respectively. There is at least one RN on duty at all times. The RN on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and a family member confirmed there are sufficient staff to meet the needs of residents.</p> <p>The Mallard (rest home) household has 10 beds and includes serviced apartments. Currently there are nine residents receiving rest home care. The clinical lead (enrolled nurse) works Monday to Friday 7 am to 3.30 pm and</p>

<p>service providers.</p>		<p>assists caregivers. A registered nurse works four days a week including two morning and two afternoon shifts. An enrolled nurse works afternoon shift on Friday and Saturday from 3 pm to 11 pm. They are supported by two caregivers on the morning shift: 1x 7 am to 3 pm, 1x 7 am to 12.30 pm. The afternoon shift is covered by one caregiver from 3 pm to 11 pm. One caregiver works night shift from 11 pm to 7 am.</p> <p>The Mary Coleman (hospital) unit has 42 beds including four swing beds and is split into two households (Kauri and Rata). The clinical lead (RN) is supernumerary and works Saturday to Wednesday. The registered nurses work three 12-hour shifts (7 am to 7.30 pm with one-hour lunch break) and one eight-hour shift per week. There are two RNs on each shift with the eight-hour shift working overnight. Each household has one registered nurse on each shift.</p> <p>Kauri household– has 22 beds, 20 residents including four rest home and 16 hospital residents. There are five caregivers rostered on the morning shift: 1x 7 am to 3.30 pm, 3x 7 am to 3 pm, and 1x 9 am to 1 pm. The afternoon shift has three to four caregivers: 2 or 3 x 3 pm to 11 pm and 1x 3 pm to 10.30 pm. There is one caregiver on overnight from 11 pm to 7.15 am.</p> <p>Rata household has 20 beds, 16 hospital level residents. Five caregivers are rostered on the morning shift: 1x 7 am to 3.30 pm, 3x 7 am to 3 pm, and 1x 9 am to 1 pm. Three caregivers work on the afternoons from 2x 3 pm to 11 pm and 1x 4 pm to 8 pm. One caregiver works overnight.</p> <p>The Buchannan (dementia) household has a total of 33 beds (18 beds in Manaaki -17 residents, and 15 beds in Aroha -14 residents). The household is staffed as one whole unit.</p> <p>The clinical lead (RN) works four days a week, (mixture of morning and afternoon shift) when there is no RN available, the hospital RN provides oversight of the level 4 caregiver. The service is currently recruiting for an RN. There are five caregivers rostered mornings and afternoon shift from 7 am to 3 pm, and 3 pm to 11 pm. There are two caregivers rostered from 11 pm to 7 am.</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</p>	<p>FA</p>	<p>Twelve electronic medication charts were reviewed (four hospital, four rest home and four dementia level). Medicines are stored in accordance with legislation and current guidelines. Medicine administration practice complies with the medicine management policy in the medicine round observed. Registered nurses, and enrolled nurses and medication competent caregivers administer medications. Caregivers complete a medication competency to check medications with medication competent staff. Medication competency and medication management education occurs at least annually. Medications are prescribed on the electronic medicine management system in accordance with legislative prescribing requirements for all regular, short course and ‘as required’ medicines.</p> <p>The GPs review the medication charts at least three-monthly. A review of medication administration records evidenced that administration of all medications aligned with the medication charts. There was one resident self-administering medications on the day of the audit in the rest home household. A medication competency has been</p>

guidelines.		signed and reviewed by the GP. Self-medicating competencies are reviewed on a three-monthly basis. Standing orders are not used. Medication fridges and room temperatures were recorded and within expected ranges.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All food is cooked on site in the commercial kitchen. Food services is led by the kitchen manager who is a qualified chef. The kitchen team includes one chef, three cooks, and 10 kitchen assistants. There is a food control plan in place. There is a food services policy and procedure manual. Food services staff have attended food safety and chemical safety training. The kitchen receives a resident dietary profile for all residents and is notified of any dietary changes. The chef then visits the resident to discuss meal options, and alternatives of residents with special diets. The chef attends the resident meetings to discuss the new seasonal menus and includes recipes and suggestions from residents. There is a four-week seasonal menu in place which has been reviewed by a dietitian. There are two lunchtime sittings with the residents on special diets and puree foods at the first sitting. There is a weekly buffet breakfast in each household. Cultural preferences and special diets are met. Likes and dislikes are known and accommodated with alternatives available. Special diets are accommodated including gluten free, vegetarian, food allergies, diabetic desserts, and pure food (puree). The main meal is at tea-time, a light lunch is served at lunchtime. Meals are delivered in thermal boxes served from a bain marie in the kitchenette on each floor. The cook and kitchenhand serve meals in the studio apartments and the caregivers serve on the care centre floor. Extra snacks are available in the dementia household 24 hours a day.</p> <p>Fridges and freezer temperatures are monitored daily. End-cooked food and hot box temperatures are recorded daily. All temperatures are within policy guidelines. Chemicals are stored appropriately. Food safety training occurs annually. Residents interviewed were overall complimentary of meals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>When a resident's condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence in the electronic file that evidences family were notified of any changes to their relative's health including (but not limited to): accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Pain charts were in use for residents on PRN pain control medication, however, these were not always completed as instructed in the care plans. Overall care plans were individualised, however, did not always reflect current needs.</p> <p>Progress notes reviewed evidenced a follow-up assessment by a RN when a caregiver documented a concern or observation or there was a change in the resident's condition. There was a total of 15 wounds (one rest home and 14 in the hospital units). Wounds included abrasions, skin tears, chronic wounds, and pressure injuries. Skin tears were categorised, and pressure injuries were appropriately staged. There was one stage 1, two stage 2 and one resolving stage 3 pressure injury. The wound care specialist has been involved with the chronic wounds and stage 3 pressure injuries. A sample of wound charts were reviewed, all wounds had individual assessments plans and evaluations and regular photographs which show progression or deterioration of the wound. A section 31</p>

		<p>notification was sighted for the stage 3 pressure injury. Adequate dressing supplies were sighted during the audit. The nurses have attended wound care and pressure injury prevention education sessions.</p> <p>The registered nurses interviewed described access to the continence and stoma services through the DHB as required. Adequate supplies of continence products were sighted during the audit.</p> <p>Monitoring forms include (but are not limited to): vital signs; fluid balance; weight; blood sugar monitoring; falls risk; pressure risk; pain risk; and behaviour monitoring.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Village at the Park employs two diversional therapists to plan, coordinate and oversee the activity/wellness programme. The wellness leader (diversional therapist) interviewed, works full time and oversees the dementia unit wellness programme. The wellness partners (caregivers) throughout the facility participate and lead activities of their interest, in line with residents' interests including (but not limited to), cooking, crafts, and music. The wellness leaders provide the resources and support the caregivers to perform their activity. A resident 'about me' social history and leisure care plan is completed soon after admission. Individual leisure plans were seen in resident electronic files. The wellness team are involved in the six-monthly review with the RN.</p> <p>There is a weekly planner developed for each household. The programme reflects activities that focus on the five pillars of living well, (engaging well, eating well, resting well, thinking well, and moving well). Activities include, newspaper reading, group games, exercises, entertainers, music therapy, flower arranging, documentary nights, aromatherapy, silent discos, folding laundry. There is an employed music therapist who visits the facility three times a week, church services are held regularly. A recent initiative includes 'walk in the life of....' which reflects the residents' previous occupations, hobbies, likes, travel, life events, birthdays, family. This information is placed on a photo frame and displayed in the residents' room. The staff and residents are in the process of developing a recipe book of favourite recipes and recipes they have been trialling during activities. Clothing protectors are being sewn from nice scarves for the ladies and shirts for gentlemen. An ice-cream cart (recycled medication trolley) now visits each area regularly with ice creams complete with a musical bell and umbrella. The sensory room continues to be well utilised and was set up on the days of the audit for residents to enjoy.</p> <p>The service receives feedback and suggestions for the programme through resident meetings. The wellness team regularly ask the residents from each area what they would like to do when planning the next programme to ensure residents suggestions are accommodated. An informal family meeting is held twice a year (not held in 2020 due to Covid-19 restrictions). The residents and relatives interviewed were happy with the activities provided.</p>
<p>Standard 1.3.8: Evaluation Consumers' service</p>	FA	<p>In the files reviewed, all initial care plans have been evaluated to develop the long-term care plans in conjunction with the outcomes of the interRAI assessments. The interRAI assessment and the long-term care plans have been reviewed six-monthly to evaluate progress towards the achievement of the desired goal (link 1.3.3.3). Case</p>

delivery plans are evaluated in a comprehensive and timely manner.		conference reviews are completed on eCase. Assessments have been reviewed six-monthly and more frequently in the event of a fall or change in health status.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current warrant of fitness which expires 16 March 2021. Equipment has been checked and calibrated. Essential contractors are available 24-hours. There is a preventative maintenance schedule. An electronic maintenance book is maintained and checked regularly throughout the day. Hot water temperatures are checked randomly in resident rooms, satellite kitchens and main kitchen monthly by the maintenance manager (interviewed). All temperatures were within range. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and courtyards on the ground floor. The outdoor areas off the dementia households are secure. Seating and shade are provided in all outdoor areas. Staff interviewed felt they have enough equipment to meet resident need.
Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>The infection control coordinator (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. A delegate from each department within the facility is part of the infection control/quality committee. Individual infection report forms are logged into the electronic resident file system, and are completed for all infections, which creates the infection register. Infections are collated in a monthly report which is analysed for trends and is included in the facility monthly report to Arvida. The infection control programme is linked with the quality management programme. The programme is reviewed annually and, on a month-by-month basis, for comparisons.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs and the infection control specialist at the DHB that advise and provide feedback/information to the service. There have been no outbreaks since the previous audit.</p> <p>Covid-19 was well prepared for with guidance from the Arvida support office. Policies procedure and the pandemic plan have been updated to include Covid-19. There are resource folders easily accessible to staff to guide them on requirements for each level of lockdown, which were quickly implemented during the recent change to level 2 over the weekends. Contact tracing remains in place in line with current guidelines. Extra training was held around donning and doffing personal protective equipment, isolation procedures, and hand washing. Hand gels are freely available throughout the facility and at the entrance of the buildings. Adequate supplies of personal protective equipment were sighted during the audit. Isolation kits are easily accessible in all households. The 2021 satisfaction results 79% of respondents were very satisfied with the way the facility responded to Covid-19.</p>
Standard 2.1.1:	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and

<p>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.2. On the day of the audit there were six hospital level residents using restraints (three lap belts and three bedrails) and no residents using enablers. Assessments, consent form and the use or risks associated with each restraint were evidenced in the three files reviewed. Staff received training on restraint minimisation and challenging behaviours via the online system. The restraint approval committee meet six-monthly, with the last meeting in October 2020. The mental health practitioner is utilised as a resource and provides training to staff.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	All residents on the ARRC contract have interRAI assessments in place. Initial assessments and relevant risk assessments have been completed within 21 days of admission to the service. Long-term care plans are in place for all residents, however, not all interRAI reassessments have been completed prior to the long-term care plan evaluations.	Two dementia, one hospital, and two rest home did not have interRAI re-assessments completed prior to the care plan evaluation.	<p>Ensure the interRAI and risk assessments are completed prior to the care plan evaluation so the long-term care plans can be updated as a result of the reassessment and evaluation.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired</p>	PA Low	The resident files reviewed evidenced care plans were in place, which contained interventions to guide caregivers on the care required for each resident, however the interventions were not always reflective of the information documented in monitoring charts, progress notes and the knowledge of the staff interviewed.	<p>Interventions in the long-term care plan for one dementia and two hospital did not reflect current needs.</p> <p>(i).The care plan did not document current</p>	<p>(i)-(iii). Ensure care plan interventions are updated when there is a change in resident condition.</p> <p>(iv). Ensure pain monitoring is recorded as instructed in the care</p>

<p>outcomes.</p>		<p>Monitoring charts were maintained as appropriate, however pain monitoring charts were not always documented as instructed in the care plans.</p>	<p>interventions as advised by the psycho-geriatrician for a dementia level resident.</p> <p>(ii). The care plan interventions around pain for a hospital resident did not include non-pharmaceutical or nursing interventions currently used to relieve pain.</p> <p>(iii). One hospital level resident with a current pressure injury did not have interventions documented around equipment currently in place and checks required.</p> <p>(iv) Pain monitoring was not documented for a hospital level resident.</p>	<p>plans.</p> <p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.