

Lansdowne Park Village Limited - Lansdowne Park Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Lansdowne Park Village Limited
Premises audited:	Lansdowne Park Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 August 2021 End date: 6 August 2021
Proposed changes to current services (if any):	No
Total beds occupied across all premises included in the audit on the first day of the audit:	57

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Lansdowne Park Village is owned and operated by the Arvida Group. The service provides care for up to 79 residents with 50 dual-purpose beds in the care centre and up to 29 serviced apartments certified to provide rest home level care. On the day of the audit, there were 57 residents in total.

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 a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff, management, and general practitioner.

The village manager is experienced and is supported by a clinical manager (registered nurse) in the care centre, the national quality manager, and the team at Lansdowne Park.

Residents and the general practitioner interviewed all spoke positively about the care and support provided.

The service implements the organisations 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.

This audit identified areas for improvement around meetings, internal audits and wound documentation.

The service has been awarded a continuous improvement around palliative care.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Staff at Lansdowne Park 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). 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

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Lansdowne Park has a current business plan and a quality and risk management programme that outlines goals for the year. Quality processes are documented. Residents'/family meetings are held regularly, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents are collated monthly and reported at facility meetings. Falls prevention strategies are in place that includes the analysis of falls incidents. There is an annual

education and training programme in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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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There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. InterRAI assessments are utilised and link to care plans. Resident files included medical notes by the general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses and wellness partners (caregivers) responsible for administration of medicines complete education and medication competencies. The medicine charts were reviewed at least three-monthly by the general practitioner.

An integrated activity programme is implemented for residents. Residents and families reported satisfaction with the activities programme. 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.

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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Lansdowne Park Village has a current building warrant of fitness. 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. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with ensuites. 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. All registered nurses hold a current first aid certificate.

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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Lansdowne Park Village has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were two residents with restraint and six residents using an enabler. Assessments and consents were fully completed. The clinical manager is the designated restraint coordinator. Staff receive training around restraint minimisation.

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.

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 evidenced 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.

Covid-19 was managed and well documented. Policies, procedures and the pandemic plan have been updated to include Covid-19. There were adequate supplies of outbreak management equipment sighted.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	47	0	2	0	0	0
Criteria	1	98	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with nineteen staff (seven wellness partners [caregivers], six registered nurses [RN], one wellness leader, one administrator [health and safety representative], one maintenance, one kitchen manager, one laundry assistant and one housekeeper) confirmed their familiarity with the Code.</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</p>	FA	<p>Informed consent processes are discussed with residents (as appropriate) and families on admission. Written general and specific consents were evident in the long-term resident files reviewed. Wellness partners and RNs interviewed confirmed consent is obtained when delivering cares. Advance directives identified the resident resuscitation status. Advance directives and medically initiated 'do not resuscitate' had been appropriately signed by the resident and general practitioner (GP). Copies of EPOA are contained within the resident file where appropriate. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. A sample of eight resident files were reviewed. Signed admission agreements were sighted in the long-term resident files reviewed. General consents were also included as part of the admission</p>

informed choices and give informed consent.		agreement.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time. There are a variety of entertainers, and college students visit residents.
<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	Lansdowne Park have 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 facility, in the library and on noticeboards throughout the facility. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is maintained. There have been six complaints received in 2020, and seven received year to date in 2021. The complaints reviewed have been managed appropriately with acknowledgement, investigation and response recorded. Corrective actions requests were implemented where appropriate. Residents interviewed advised that they are aware of the complaints procedure and how to access forms. Resident meetings provide a forum for residents to provide suggestions and feedback on all areas of the service. The management provide an open-door policy. Relatives interviewed stated they felt comfortable discussing concerns with the management team.

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service can 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 or clinical manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code. Interviews with six residents (four rest home and two hospital) and three relatives (hospital level) confirmed the services being provided are in line with the Code.</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>	<p>FA</p>	<p>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting residents' privacy and could describe how they manage maintaining privacy and respect of personal property. There is a policy that describes spiritual care. Church services are conducted regularly. All residents interviewed indicated that residents' spiritual needs are being met when required. Staff receive training on abuse and neglect. Staff interviewed could describe how they ensure privacy is maintained.</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>	<p>FA</p>	<p>The service has established cultural policies to help meet the cultural needs of its residents. There was one resident and seven staff who identified as Māori at the time of the audit. The resident file identified the resident's individual preferences around culture and whānau involvement. There are links with Ngati Kahungunu and Rangitane o Wairarapa who provide advice and guidance on cultural matters. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review as demonstrated in the resident files sampled. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The</p>	<p>FA</p>	<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. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which</p>

<p>Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural safety/awareness. The 2021 resident satisfaction survey evidenced 63% of residents felt they were treated as individuals.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>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. 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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<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 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.</p> <p>The team at Lansdowne Park are implementing the organisational 'Attitude of Living Well' model of care, which is based around a household model of care. This model embodies resident-centred care that looks to remove institutionalised approaches to care and staffing tasks. Staff and residents gathered to brainstorm and discuss how they would like to establish a more homelike environment that focuses on resident choice and the moving away from institutionalised 'task focused' care. Each of the new leadership teams worked together to design their own preferences for the household. Residents and staff discussed resources needed and changes to the way the wing functions. All wings Kauri, Rimu, Matai & Apartments: wake-up times were removed, and residents are now able to sleep and wake at times of their choosing. Breakfast is served to residents when it suits them. There is a buffet breakfast daily which encourages independence so that capable residents can serve themselves and it also allows residents to have their breakfast and wake-up times when it suits them. There is a cooked breakfast provided monthly. Leaders were established for each household team and the Wellness Leader worked with the teams to establish pillar champions. The Wellness (activity) team are beginning to create a thriving, dynamic, engaging, and varied programme of initiatives which cover so many different areas of interest and holistic engagement. Resident satisfaction at regular meetings and family feedback are being monitored as the implementation of the programme</p>

		<p>progresses, to ensure this becomes established as the new normal. It is amazing to watch a more integrated holistic activity programme emerge.</p> <p>The service has been awarded a continuous improvement around the preparation and delivery of palliative care.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>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. Fourteen incidents/accidents reviewed had documented evidence of family notification or noted if family did not wish to be informed. Interpreter services are available as required.</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>	FA	<p>Lansdowne Park Village is owned and operated by the Arvida Group. The service provides care for up to 79 residents with 50 dual-purpose beds in the care centre and up to 29 serviced apartments certified to provide rest home level care. On the day of the audit, there were 57 residents in total. There were 35 residents at rest home level (24 in the care centre and 11 in the serviced apartments) and 22 residents at hospital level care, including one resident on respite, three funded by ACC and one resident on a long-term support chronic health contract (LTS-CHC). All other residents were under the age-related residential care (ARRC) agreement.</p> <p>There is a village manager (RN) who was not available on the days of the audit. The village manager is supported by a clinical manager who has been in the role for two years and has previous experience of clinical management and senior registered nurse roles within aged care. They are supported by the National Support Office team, the national quality manager (present during the audit), an administrator, and a team of registered nurses, wellness partners and non-clinical staff.</p> <p>The village manager reports to the CEO 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. Lansdowne Park Village has a business plan and a quality and risk management programme. The business plan is reviewed on a six-monthly basis.</p> <p>The village manager and clinical manager have completed in excess of eight hours of professional development in the past 12 months.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the village manager, the clinical manager is in charge. Support is provided by the national quality manager and the national support office team, and the Lansdowne Park staff.</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>PA Low</p>	<p>There is an implemented quality and risk management system in place at Lansdowne Park designed to monitor contractual and standards compliance. There is a business/strategic plan that includes quality goals and risk management plans. There is an established culture of seeking to continually review and analyse data to improve resident outcomes. 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. Arvida Group policies are reviewed at least every two years across the organisation.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been documented, however these are not always completed according to the schedule. Areas of non-compliance identified through quality activities are actioned for improvement. Meeting minutes available evidenced meetings were not held according to schedule, and the minutes did not evidence discussions with staff around quality data. Quality data is benchmarked monthly and quarterly within the organisation, and a national organisational framework.</p> <p>Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The January 2021 resident/relative satisfaction survey overall result shows 81% of respondents were very satisfied with services provided. Resident/family meetings occur two-monthly, and the results of the satisfaction survey have 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 at the fortnightly meetings which are held following the virtual national health and safety meeting. The administrator and the maintenance person (health and safety representatives) were interviewed. The Lansdowne Park health and safety committee is representative of the facility. Hazard identification forms and an up-to-date hazard register is in place through the Mango system. Committee members have attended external health and</p>

		<p>safety in the workplace training.</p> <p>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>	FA	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs, however minutes of meetings did not evidence discussion of incidents/accidents at staff meetings including actions to minimise recurrence (link 1.2.3.6). An RN conducts clinical follow-up of residents. A sample of fourteen incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for all unwitnessed falls or potential head injuries. Discussions with the clinical manager and the National Quality manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been section 31 forms completed for a resident absconding and an unstageable pressure injury. The public health service was contacted for two outbreaks (one norovirus in 2019 and one gastroenteritis outbreak in 2020).</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. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Ten staff files were reviewed (one clinical manager, two RNs, four wellness partners, one wellness leader and one kitchen manager and one housekeeper). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in nine of the ten staff files reviewed (one staff member had not been employed for less than six months). 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. 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 wellness partners and RNs confirmed that Altura online training is available and implemented by staff. More than eight hours of staff development or in-service education has been provided annually. There are nine RNs at Lansdowne Park, and seven have completed interRAI training. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the DHB and Hospice.</p> <p>Wellness partners are encouraged to complete New Zealand Qualification Authority (NZQA). Currently there are 11 wellness partners who have completed Level 4 NZQA, 15 wellness partners have completed level 3, and six</p>

		have completed level 2. Competencies completed by staff included medication, insulin, wound care, manual handling, hand hygiene, syringe driver and restraint, there was an up-to-date register.
<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>Lansdowne 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 84 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 are two RNs on duty at all times on morning and afternoon shifts who cover Kauri and Rimu homes and oversee Matai. One RN is rostered overnight. The RN on each shift is aware that extra staff can be called on for increased resident requirements. There are dedicated housekeeping and laundry staff. Interviews with staff and residents confirmed there are sufficient staff to meet the needs of residents.</p> <p>Matai home has 17 beds with 15 rest home residents and two hospital level residents.</p> <p>There are two wellness partners rostered on the morning shift from 7 am to 3 pm. Afternoon shift has two wellness partners rostered: 1x 3 pm to 11 pm and 4 pm to 9.30 pm.</p> <p>Kauri home has 17 beds with 14 residents; ten hospital level including two residents funded by ACC and one resident on respice care, and four residents at rest home level care.</p> <p>There are three wellness partners rostered non-morning shifts: 7 am to 3 pm. The afternoon shift has two wellness partners: 1x 3 pm to 11 pm and 1x 3 pm to 9.30 pm.</p> <p>Rimu home has 16 beds with 15 residents; 10 hospital; including a resident funded by ACC, and five rest home residents.</p> <p>There are two wellness partners rostered from 7 am to 3 pm, there is a 'float' wellness partner shared between Kauri and Rimu homes from 8.30 am to 1 pm. There are two wellness partners rostered on the afternoon shift: 1x 3 pm to 11 pm and 1.30 pm to 9.30 pm.</p> <p>In the serviced apartments there were 11 rest home residents. The serviced apartments have one wellness partner on the morning shifts from 7 am to 3 pm. One wellness partner works from 8 am to 4 pm, and one wellness partner works from 3 pm to 11 pm.</p> <p>Night shift for the facility is covered by three wellness partners and a registered nurse.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</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 electronic record. Residents' electronic files are protected from unauthorised access by individual passwords. Other residents or members of the public</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>cannot view sensitive resident information. Entries in records are legible and dated by the relevant wellness partner or RN.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed align with all contractual requirements and kept within the electronic file. Exclusions from the service are included in the admission agreement. Enduring power of attorney activation letters were placed on file where applicable.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There are 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 are involved for all exit or discharges to and from the service. Two resident files reviewed included DHB discharge summaries following acute hospital visits.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs and wellness partners) have been assessed for competency on an annual basis. Annual education around safe medication administration has been provided. Registered nurses complete syringe driver training. Monthly delivery of robotic packs is checked against the medication charts by the RNs. The medication fridge and room temperatures are checked daily and maintained within the acceptable temperature range. All eye drops and ointments sighted were dated on opening. Residents self-medicating are managed according to policy. There were no residents self-medicating on the day of audit. Standing orders are not</p>

<p>current legislative requirements and safe practice guidelines.</p>		<p>used.</p> <p>Sixteen medication charts were reviewed across the rest home/hospital and serviced apartments. All had photo identification and had been reviewed by the GP at least three-monthly. Medication charting is completed electronically by the GP. 'As required' medication had indications for use. A medication round was observed, and the RN completed the administration process correctly. Nutritional supplements are documented and administered from the electronic medication chart.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Lansdowne has a commercial kitchen where all food is prepared and served. The chef (kitchen manager) has been in the role for seven months and is well experienced with aged care. The service employs another two cooks, four kitchenhands and a kitchen assistant. The kitchen manager has weekly meetings with the national hospitality manager and is supported by the Arvida national dietitian. All have completed food safety certificates. When interviewed they explained the procurement of the food and management of the kitchen. The service has a verified food control plan 14 June 2022.</p> <p>Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Temperatures are recorded on frozen foods on delivery. All dry foods were stored in sealed containers and dated. Perishable foods sighted in the fridges were dated. The chemical supplier checks the dishwasher regularly. Staff have received training in chemical safety. Chemicals are stored safely. A maintenance and cleaning schedule is maintained.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access and were reflective of residents' current choices, likes and dislikes. Special diets were noted on the kitchen noticeboard. Dietary supplements are available.</p> <p>The menu is a four-weekly seasonal menu. Residents and families interviewed, overall stated satisfaction with the food.</p> <p>Food is served directly through the serving hatch from the bain maries in the main kitchen to the large dining room. Food is covered and transported on trolleys from the main kitchen to the serviced apartment kitchenette and to the small dining room in the rest home. A number of residents prefer their meals in their rooms.</p> <p>The late afternoon meal was observed in the Rimu and Kauri dining room. The staff assisting residents with their meals promoted and encouraged dining room ambience. There were enough staff to assist with meals in a timely manner and specialised cutlery was available.</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>	FA	<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 communicates 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>	FA	<p>The RN completes an initial assessment on admission including risk assessment tools. A long-term care plan is completed within 21 days of admission and thereafter six-monthly, or earlier due to health changes. All long-term resident files reviewed identified interRAI assessment notes and summaries were available. The outcomes of assessment tools are linked to the long-term care plan. The resident needs, goals and supports are documented in the long-term care plans.</p> <p>The resident on respite care had a range of assessments completed within 24 hours of admission to complete the initial care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident care plans reviewed (electronic) were resident-focused and individualised. A range of assessments including interRAI have been completed and linked to care plan interventions. Overall long-term care plans evidenced updates to care plans as changes to resident's health occurred. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. There was evidence of allied health care professionals involved in the care of the resident including the GP, physiotherapist, mental health team, podiatrist, hospice and dietitian.</p>
<p>Standard 1.3.6: Service</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</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>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.</p> <p>There has been increased nurse specialist support through referral to geriatric nurse specialist, respiratory nurse specialist, wound nurse specialist.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. The wound register was reviewed and a sample of nine wounds including the two recently healed pressure injuries (one stage I, one stage III). Wound assessment and management plans, including evaluation notes were in place, however not all were fully completed.</p> <p>The service can access the DHB wound nurse specialist if required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Specialised equipment including sensor mats, hoists (standing and full), transfer belts, lap belts, pressure relieving mattresses and cushions were available for use. There is a process where equipment (including individualised equipment used by the resident on LTS-CHC) is checked for safety and maintained by the appropriate services. The service procured recently new equipment including oxygen concentrators, recliner chairs, standing hoist, bariatric hoist and new slings. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p> <p>Monitoring records for (but not limited to) weight, catheter changes, toileting charts, food and fluids, blood sugars, behaviours and routine observations including neurological observations after unwitnessed falls demonstrates monitoring occurs. These were sighted across the files reviewed. The RN monitors and reviews the monitoring forms daily on the electronic system. The wellness partners report any changes to the RN.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Arvida is operationalising their vision 'to transform the ageing experience' within the care communities through the introduction of the wellness/household model. 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. Lansdowne has introduced the wellness/household model and is working towards fully implementing the model. A resident delegate attends the wellness meeting. The introduction of the wellness meeting has given the residents a strong voice into how the facility should be run and they provide feedback in the activity programme.</p> <p>The service employs a registered nurse in the role of wellness leader. The wellness leader works 30 hours per week from Monday to Friday. The wellness leader and RNs complete an initial assessment activities profile, and activity care plan. Evaluations are completed six-monthly as part of the multidisciplinary team review. Care plans acknowledge spiritual and cultural needs.</p> <p>Wellness partners are considered to be part of the activities team and facilitate activities during the week and the in</p>

		<p>the weekends. The wellness leader provides individual and group activities for rest home and hospital residents that meet the abilities and preferences of the residents. There are three separate programmes for each area (hospital, rest home and serviced apartments) with integrated activities for entertainers, crafts, newspaper reading, church services and pre-dinner drinks.</p> <p>The programme aligns with the Wellness model of thinking well, engaging well and moving well. Activities are held in the main lounge dining room, and smaller group activities can run concurrently in the smaller lounge/library.</p> <p>Community links include visiting university students, attending concerts and shopping visits. One-on-one activities such as individual walks, reading and chats and nail/hand care for residents who are unable or choose not to be involved in group activities. There is a van that goes out regularly and includes outings mainly for rest home/serviced apartment residents. Rest home residents in the serviced apartments can also attend the activities programme in the village community centre ("The Landing").</p> <p>Household meetings are held weekly and include the four wellness team leaders.</p> <p>Rest home residents in the serviced apartments are invited to participate in the activities in the care centre. Individual leisure activity plans were seen in all resident files reviewed. The service receives feedback and suggestions for the programme through resident meetings and surveys. Residents interviewed described providing suggestions for the next planner.</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>The clinical manager or an RN evaluated all initial care plans (sampled) within three weeks of admission. The multidisciplinary team has reviewed long-term care plans at least six monthly or earlier for any health changes. Family are invited to attend the MDT review and are informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and documented within the progress notes and are evident in changes made to care plans.</p>
<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</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>

providers is appropriately facilitated, or provided to meet consumer choice/needs.		
<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>Documented processes for the management of waste and hazardous substances are in place. Safety datasheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored safely and secure throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training. There is a secure sluice in the care centre and a small laundry in the serviced apartments. Spill kits are set up for use when needed.</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>The building has a current building warrant of fitness that expires 20 November 2021. The service employs a fulltime maintenance person who is a health and safety representative and is on call 24/7 for any maintenance issues. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained that includes internal and external building maintenance. The maintenance person has been certified to conduct electrical testing which is completed two yearly. An external contractor completes annual calibration and functional checks of medical equipment.</p> <p>There are three wings on the ground floor:</p> <p>The Kauri and Rimu wings on the ground floor are all dual-purpose rooms but are mainly occupied by hospital level residents. The Matai wing is all dual-purpose rooms but mainly occupied by more able rest home residents.</p> <p>On the first floor there are three wings and a total of 29 serviced apartments, and all are able to have rest home level care residents. There were eleven rest home residents across the three wings on the day of the audit with one married couple (both rest home level) in a one-bedroom apartment. The serviced apartments are spacious with enough room for mobility equipment.</p> <p>The wellness partners and RNs interviewed stated they have sufficient equipment to safely deliver resident cares.</p>

		Hot water temperatures in resident areas are monitored and maintained below 45 degrees Celsius. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to mobilise safely within the facility. There is a lift between floors which is large enough for ambulance equipment if needed. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating and gardens. There is a pond situated behind the community centre. The pond is visible by staff and residents within the village. There have been no incidents of residents wandering near the pond.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	All resident rooms in the care centre on the ground floor have full ensuites. Communal toilets are located closely to communal areas. A large shower room situated in the hospital includes a shower trolley. All serviced apartments on the first floor have a full ensuite. Toilet and shower facilities are of an appropriate design to meet the needs of the residents. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant and locks are on doors. The serviced apartments have spacious ensuite toilet and shower facilities with enough room for wellness partners to assist safely.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All rooms are single and personalised. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms. This was evident on the day of audit.

<p>Standard 1.4.5: Communal 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>FA</p>	<p>There is a large communal lounge and smaller lounges/sitting areas in each wing for quieter activities and visitors, to give more of a smaller household feel. There is a large main dining room and a smaller dining area off the rest home wing. There is also an open plan dining area for the serviced apartment residents including rest home residents on the first floor. There is a large activity room for activity groups and church services. A library and computer room are situated near the entrance. Seating and space in the main lounge are arranged to allow both individual and group activities to occur. All communal areas are easily accessible for residents to assist using mobility aids or with staff assistance.</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>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There is a dedicated laundry and cleaners on duty seven days a week. The laundry and cleaning staff have completed chemical safety training. The laundry is located in the rest home/hospital wing and has a sluice area with appropriate personal protective clothing readily available. There is an entry and exit door with defined areas for clean and dirty laundry. The cleaners' trolleys are stored in a locked area when not in use. Internal audits monitor the effectiveness of the cleaning and laundry processes. The chemical supplier conducts quality checks on the effectiveness of washing and 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>	<p>FA</p>	<p>There is an emergency and disaster management plan in place to ensure health, civil defence and other emergencies are included. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service on 16 November 2012. Six monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 22 June 2021. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility.</p> <p>There is sufficient water stored in a water tank. There is adequate food supply, gas cooking (BBQ and gas hobs in the kitchen) and a small generator on site. Civil defence supplies are available in the event of an emergency (checked every six months). Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in</p>

		<p>the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p> <p>Call bell points are available in the serviced apartments (two in the bedroom, lounge and shower).</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The underfloor heating throughout the facility is centrally controlled. There are overhead heating/cooling air conditioning systems in the lounges.</p> <p>The residents and family interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. A registered nurse is the designated infection control coordinator with support from the management team and members of the infection control team, who are representative of the facility. Infection control is discussed at the quality meeting, minutes are available for staff to read, however the meeting minutes did not reflect the discussions held around data with staff (link 1.2.3.6). Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Arvida infection control programme has been reviewed annually.</p> <p>Hand sanitiser is available at the main entrance and throughout the facility. Adequate supplies of personal protective equipment were sighted. All visitors to the facility complete a wellness declaration and sign a register for contact tracing purposes in line with current Covid-19 lockdown guidelines. Visitors are reminded not to visit the facility if they are feeling unwell.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>The designated infection control (IC) coordinator has been in the role for two years. All members of staff are required to complete online Altura learning for infection control education. In-service education is held on topical issues by the infection control coordinator. The infection control coordinator has access to expertise within the organisation, local laboratory, DHB infection control team, public health team, and the GPs. There are adequate</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>resources to implement the infection control programme for the size and complexity of the organisation.</p> <p>There is a Covid-19 resource folder and pandemic/outbreak cupboard with sufficient personal protective clothing and hand sanitisers. Isolation kits are set up ready for use in isolation rooms. There were weekly zoom meetings with Arvida support office and a consultant virologist during lockdown providing a forum for discussion and support for facilities. Screening logs were maintained during the lockdown levels. Regular stocktakes are performed around PPE stocks and infection control supplies.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>Arvida group infection control policies and procedures meet best practice. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Policies and procedures are reviewed at support office in consultation with infection control coordinators. Policies are available on the intranet. Policies and the pandemic plans have been updated to include Covid-19.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. All staff complete infection control education on the Altura system. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records. Extra education was provided during the Covid-19 period. Compulsory education sessions were made available for staff around donning and doffing personal protective equipment (PPE), handwashing, and an online course. Zoom meetings were held with the Arvida infection control team during the Covid lockdown period. The infection control coordinator has attended</p>

staff, and consumers.		two infection control study days held through the DHB.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	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 standard definition of signs and symptoms of infections. Surveillance of all infections is entered into the monthly online infection control register. The wellness and care team (support/head office) monitor current infections. This data is monitored and evaluated monthly, six-monthly and annually. Trends and analysis of infections and corrective actions are discussed at the quality committee meetings, however not always discussed at the staff meetings (link 1.2.3.6). Benchmarking occurs within the Arvida Group and a national organisational benchmarking group.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>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 two hospital residents on restraint (one with a chair brief and one with a bedrail) and six residents with an enabler (bedrails and lap belts). Enabler use is voluntary. Assessments and consents were in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint has been discussed as part of quality committee meetings. Staff receive training around restraint minimisation.</p>
<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</p>	FA	<p>The clinical manager is the designated restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident or representative and medical practitioner.</p>

use and this process is made known to service providers and others.		
<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	Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident or representative and medical practitioner. 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.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes implemented. Monitoring forms included regular two hourly monitoring. The service has a restraint and enablers register, which was up to date.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	The restraint evaluation is required to include the areas identified in 2.2.4.1 (a) – (k). Evaluations are to be completed by the restraint coordinator at least three monthly or earlier if required. Two resident files reviewed identified a current evaluation. The case conference (MDT six-monthly review) also includes a review of restraint use with the family.
<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>	FA	Restraint usage is monitored regularly by the restraint coordinator. Corrective actions are monitored; however, restraint was not always evidenced as being discussed at the quality committee or staff meetings (link 1.2.3.6). Individual restraint use is monitored and recorded by staff.

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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	A range of quality data is collated and analysed for trending by the clinical manager. Meeting minutes evidenced meetings were not always held according to schedule and did not evidence discussion with staff around quality data and trending. An internal audit schedule has been documented; however, these have not always occurred as scheduled. Corrective actions identified have been completed and signed off.	<ul style="list-style-type: none"> i) Meeting minutes were not documented as occurring as scheduled including quality meeting, wellness partner meetings, clinical meetings, infection control meetings and restraint approval. ii) Meeting minutes reviewed did not evidence discussions with staff around quality data collated. iii) Internal audits for 2020 could not be located, and the internal audits for 2021 have not been completed according to schedule. 	<ul style="list-style-type: none"> i) and ii) Ensure all meetings scheduled are held and minutes evidence discussion with staff around quality data. iii) Ensure all internal audits occur

				<p>as scheduled, and results are evidenced as discussed in relevant meetings.</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 outcomes.</p>	<p>PA Low</p>	<p>The current wound register was reviewed including two recently resolved pressure injuries. Wound assessment and management plans, including evaluation notes were in place for all wounds reviewed. However, progression towards wound healing (wound bed, exudate level and surrounding skin) were not always completed for seven of the nine wounds.</p> <p>A range of monitoring forms are used including vital signs, neurological observations, weight, blood glucose levels, positioning, enabler monitoring, food and fluid intake, behaviour, toilet schedules and pain.</p>	<p>Wound assessment and management plans for seven of nine wounds (including two pressure injuries) did not document progression towards healing.</p>	<p>Ensure wound assessment and management plans are fully completed</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<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>Introducing conversations around Advanced Care Planning early in developing relationships with new residents and families entering Lansdowne Park Care Centre, stemmed from a year-long project in 2020 that reviewed the quality of care and</p>	<p>An audit conducted in June 2020 found that only 62% of residents had an advance directive for healthcare (ADHC) on file and 31% had an Advance Care Plan. By September 2020, the service improved the statistics of residents with an ADHC on file to 89% and introduced Advance Care Plan guidelines for discussion to be included in admission information packs. A new admission information pack was developed to cut down on the time required for RNs to spend asking questions on day one of admission, enabling the resident more time to relax and acclimatise to a new environment. It enables resident and family to consider both current and advance care-planning information prior to entering ARC. Advance Care Planning (ACP) is no longer a ‘surprise’ topic. The Wairarapa DHB approached Lansdowne Park in July 2021, to aid in the implementation of a system for using an Advance Care Guide to provide a single ‘point of reference’ for each resident for Advance Care Planning, which can be shared across the resident’s information platform with primary care and hospital services. The document is loaded into Medimap which is a shared platform for ARC and primary care. It is clearly identified in the residents ARC folder and is included in the yellow envelope transfer system if the person is transferred to hospital. The person’s preferences in their advance care guide are revisited as part of their care plan reviews or beforehand if their health status changes. Registered nurses interviewed</p>

	<p>service provision to residents – with a focus on palliative care.</p> <p>It acknowledged the trend now seen for age residential care (ARC) facilities being used increasingly as a hospice service for short-term end-of-life [EOL] stays. The admission process was the aspect of Lansdowne’s customer service where it was seen could make significant improvements that would be two-fold.</p> <p>i) An opportunity to address workforce preparedness to manage increasing numbers of admissions by providing a framework within a system that enables</p>	<p>stated they felt more confident discussing advance care planning with residents and relatives.</p>
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		<p>registered nurses [RNs] to work smarter rather than harder and build RNs' confidence in timing conversations about Advance Care Planning.</p> <p>ii) An opportunity to improve the experience of new residents and their families entering ARC, at a time when they are most vulnerable and are having to adapt to many changes.</p>	
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End of the report.