

Views Lifecare Limited - Bethlehem Views

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:

Legal entity:	Views Lifecare Limited
Premises audited:	Bethlehem Views
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 10 November 2021 End date: 11 November 2021

Proposed changes to current services (if any): The service applied to the Ministry of Health (letter dated 16 June 2020) which would increase bed numbers from 89 to 90 (a dual-purpose bed to be verified in a shared room). This was to accommodate a married couple. The service no longer wishes to progress the increase in bed numbers. They have also asked to decrease bed numbers from 89 to 88 (noting that a dual-purpose bed was verified and confirmed at the certification audit to accommodate a married couple who wished to share a room). The number of beds is confirmed at this audit to be 88.

Total beds occupied across all premises included in the audit on the first day of the audit: 88

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

Arvida Bethlehem Views is part of the Arvida Group. The service is certified to provide rest home, hospital, and dementia level of care for up to 88 residents. On the day of the audit there were 88 residents in the care centre.

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

The clinical manager has been covering the interim village managers position since May 2021. The clinical manager is a registered nurse and has been in the clinical managers role for six years. She is supported by a clinical team leader, an education/health and safety coordinator, two team leaders (registered nurses) and a team of experienced staff.

There is an organisational business, and quality and risk plan documented. The residents, relatives and the general practitioner spoke highly of the staff and care provided at Bethlehem Views.

There were no shortfalls identified at the previous audit.

This audit identified shortfalls around meeting minutes and care plan 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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Policies are implemented to support residents' rights, communication, and complaints management. 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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Bethlehem Views has a current business plan and a quality and risk management programme that outlines goals for the year. Meetings are held to discuss quality and risk management processes. An internal audit programme identifies corrective actions and areas for improvement which have been implemented. 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.

There is an annual education and training programme documented. Appropriate employment processes are documented. 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 medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans reviewed in the electronic resident records were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

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

The activity team provide and implement an interesting and varied integrated activity programme for each resident group. The programme includes integrated activities, community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and resident preferences.

All meals are prepared and cooked on site. Residents' food preferences and dietary requirements are identified on admission. Dislikes and special dietary requirements are met. The menu has been reviewed by a dietitian. There are snacks available 24 hours.

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 building holds a current warrant of fitness and there is a reactive and planned maintenance plan in place. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. The dementia care household has a safe outdoor walking pathway, gardens, and grounds.

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. The service has remained restraint free for four years. On the day of the audit there were no residents with any restraints and three residents using an enabler. Staff receive training in restraint minimisation annually.

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.

The clinical lead is the infection control coordinator, which is overseen by the clinical manager. 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 at the quality and risk meeting.

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	0	15	0	1	1	0	0
Criteria	0	41	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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>	<p>FA</p>	<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. A complaints register is available.</p> <p>There have been three complaints received since the previous audit, one in late 2019, none in 2020, and two (year to date) in 2021. The complaints reviewed have been managed appropriately with acknowledgement, investigation and response recorded. Residents and relatives interviewed advised that they are aware of the complaints procedure and how to access forms, and all felt comfortable discussing concerns with the registered nurses or management team.</p> <p>Staff interviewed (seven caregivers [wellness partners], two registered nurses, one team leader (dementia), one maintenance man, one education/health and safety coordinator, two diversional therapists [wellness leaders] one chef and one cook) were all aware of the complaint's procedure in relation to their role.</p> <p>There have not been any complaints from external authorities since the last audit.</p>
<p>Standard 1.1.9:</p>	<p>FA</p>	<p>Three residents interviewed (two rest home and one hospital) stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and</p>

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>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. Twelve incident/accidents reviewed had documented evidence of family notification or noted if family did not wish to be informed. Interpreter services are available as required. The five relatives interviewed (three dementia, and two hospital) stated they were promptly informed of any changes in resident health and all incidents. Residents and family interviewed that they were kept updated around protocols for visiting and Covid related issues.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The certification audit stated that there were 89 beds following verification at that audit to increase bed numbers by one (total of 89 beds with a single room verified to include two dual purpose beds). The service had applied at this audit to the Ministry of Health (MoH) to reconfigure one room to include two dual purpose beds to accommodate a married couple (this would have taken the number of beds to 90). This configuration is no longer required. The service has also decided to remove the dual-purpose bed verified at the certification audit as there is no requirement to support a married couple.</p> <p>The total number of beds at this audit is confirmed to be 88 (all single rooms). On the day of the audit, all rooms were single occupancy.</p> <p>Bethlehem Views is owned and operated by the Arvida Group. The service provides care for up to 88 residents in total including 20 beds in the memory care (dementia) care unit, and 68 in the dual-purpose rest home and hospital units.</p> <p>On the day of the audit there were 88 residents in total, including 20 residents were in the dementia unit, 22 rest home residents and 46 hospital including one resident on a long-term support- chronic health contract (LTS-CHC) and one resident on a younger person with a disability (YPD) contract. The remaining residents were all under the age-related residential contract ARRC).</p> <p>The clinical manager (registered nurse) has been in her role for six years. The clinical manager has been covering the interim village manager role since May 2021. She is supported by a clinical team leader (RN) who has been in her role for three years, an education/health and safety coordinator, who has been in the role for three years and two-unit coordinators (one dementia and one rest home/ hospital). A village manager has been appointed and is due to commence on 8 December 2021. They are supported by the organisational team and a stable experienced team of staff.</p> <p>The clinical manager reported a low turnover of staff. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Bethlehem Views Lifecare has a business plan 2020/2021 and a quality and risk management programme.</p> <p>The clinical manager has been in her role for six years and has previous experience in age care. The clinical</p>

		<p>manager has been in the acting manager role for five months. The service has recruited a general manager who is due to commence the role in early December. The team are supported by the national quality manager and the team at the support office. Due to covid restrictions support was provided through Teams virtual meetings.</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>	PA Low	<p>There is a documented quality and risk management system in place at Bethlehem Views which is designed to monitor contractual and standards compliance. There is a 2020/2021 business/strategic plan that includes quality goals and risk management plans for the service. At present, the clinical manager is 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 group.</p> <p>Monthly quality risk restraint and infection control meetings are held monthly, a separate monthly health and safety meeting is held. The quality, risk restraint and infection control meeting minutes evidenced discussion around all aspects of the service, including quality data collated monthly, however, not all meetings have been held according to schedule, and not all meeting minutes could be located. The full facility meeting has been held six monthly as scheduled, however, there was no evidence of discussions around quality data with staff.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement.</p> <p>Residents/relatives are surveyed to gather feedback on the service. The 2020 and 2021 survey results were very similar and evidenced overall satisfaction with the service. Household meetings have been held in November 2021 for each household for the first time, however, resident meetings have not been held according to schedule.</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 which has been held monthly as scheduled. There are also monthly national health and safety meetings conducted online through Zoom. Hazard identification forms and an up-to-date hazard register is in place through the Mango system. 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</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. An RN conducts clinical follow-up of residents.</p> <p>Incident forms reviewed for October and November 2021 demonstrated that appropriate clinical follow up and investigation occurred following incidents. Neurological observation forms were documented and completed for unwitnessed falls or potential head injuries. The GP has reviewed residents in the dementia unit who fall. The GP has sanctioned that no neurological observations are to be completed for certain residents as this increases</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>challenging behaviours. The list was sighted during the audit and the clinical coordinator described monitoring of the resident post falls.</p> <p>Discussions with the clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been section 31 incident notifications made following a coroner's inquest, and for non-facility acquired stage 3 pressure injuries. The support office has completed section 31 notifications for the change in management.</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>	<p>FA</p>	<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. Eight staff files were reviewed (one clinical manager, the team leader of the dementia unit, one RN, one diversional therapist, and four wellness partners). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were completed in 2020 for four of the staff files reviewed, one was completed in 2021, one was recently recruited, and two were reported by the clinical manager as scheduled to occur.</p> <p>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 documented. 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. Competencies completed by staff included medication, insulin, wound care, manual handling, hand hygiene, syringe driver and restraint, there was an up-to-date register. All staff have a current first aid certificate.</p> <p>There are 15 registered nurses and nine have completed interRAI training. The clinical manager and RNs are able to attend external training, including sessions provided by the DHB. Staff are encouraged to gain New Zealand Qualification Authority (NZQA) qualifications through Careerforce. Currently there are 25 wellness partners who have gained level 4, 18 who have completed level 3, and 16 who have completed level 2.</p> <p>There is a total of 15 wellness partners who work in the dementia unit, 12 have completed the required dementia standards, two are in the process and one has recently been employed. All staff working in the dementia unit have completed a comprehensive induction to include challenging behaviours and dementia.</p>
<p>Standard 1.2.8: Service Provider</p>	<p>FA</p>	<p>Bethlehem Views 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 120 staff. Rosters were sighted and there is staff on duty to meet the resident needs. The clinical manager works 40 hours per week and shares on call with the clinical team lead</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>(dementia unit). They are available on call after-hours for any operational and clinical concerns. 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. 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>The Eliza Benfell Suites (dementia unit) had full occupancy of 20 residents on the day of the audit. The clinical team lead (registered nurse) is rostered Monday to Friday from 8.30 am to 4 pm. The RN from the rest home/hospital unit provides clinical oversight when the clinical team lead is not available. A registered nurse is also rostered from 9 am to 4.30 pm across Monday to Friday. All shifts have at least one senior wellness partner who has a current first aid certificate and medication competency.</p> <p>The morning shift has four wellness partners rostered; 2x 7 am to 3 pm, 1x 7.30 am to 2 pm and 1x 8 am to 2.45 pm. The afternoon shift has four wellness partners rostered 2x 3 pm to 11 pm, 1x 4 pm to 9.30 pm, and 1x 4.30 pm to 9.30 pm. The nightshift is covered by two wellness partners: 1x 11 pm to 7am and 1x 11.15 pm to 7am.</p> <p>Cambridge suites has 25 beds with 25 residents on the day (16 hospital [including one resident on YPD contract and one resident on LTS-CHC] and nine rest home).</p> <p>There is one registered nurse on duty on morning and afternoon shifts, who is supported by three wellness partners on the morning shift; 2x 7 am to 3 pm, 1x 7 am to 3 pm, 1x 6 am to 2.30p m. There is a float wellness partner who works between Cambridge and Sanderson Suites from 6 am to 2.30 pm.</p> <p>The afternoon shift has four wellness partners: 3x 3.30 pm to 10 pm and 1x 3.30 pm to 12midnight.</p> <p>Sanderson suites has 24 beds with 24 residents (20 hospital level, and four rest home).</p> <p>The registered nurse on morning and afternoon shifts, is supported by five wellness partners on the morning shift; 3x 7 am to 3.30 pm, 1x 7 am to 3 pm and 1x 7.15 am to 1.45 pm. They are also supported by the 'float' who works between Cambridge and Sanderson suites on a morning shift. The afternoon shift has five wellness partners: 3x 3.30 pm to 10 pm and 2x 3.30 pm to 12 midnight.</p> <p>Kaimai suites has 19 beds with 19 residents (nine hospital and 10 rest home).</p> <p>The registered nurse is rostered on morning and afternoon shifts and is supported by three wellness partners on the morning shift: 2x 7 am to 3.30 pm and 1x 7 am to 3 pm. The afternoon shift has 1x 3.30 pm to midnight and 2x 3.30 pm to 10 pm.</p> <p>Nightshift across the rest home/hospital units is covered by one registered nurse and three wellness partners.</p> <p>Cambridge, Sanderson and Kaimai is covered by three wellness partners and two RNs overnight.</p>
<p>Standard 1.3.12:</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management. Medications are stored safely in the</p>

<p>Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>four households. Clinical staff who administer medications (RNs, enrolled nurses, and medication competent caregivers) have been assessed for competency on an annual basis and attend annual medication education. Registered nurses have completed syringe driver training. All medication (robotic rolls) are checked on delivery and signed as pack checked on the electronic medication system. The hospital impress stock is checked monthly by the supplying pharmacy. Standing orders are used and meet the requirement including annual review by the GP. A self-medication assessment and three-monthly review had been completed for one rest home resident self-medicating inhalers. The medication fridge is checked daily, and temperatures are maintained within the acceptable temperature range. The temperature of all medication rooms are checked daily and have been maintained below 25 degrees Celsius. All eye drops sighted in the medication trolleys were dated on opening.</p> <p>Twelve medication charts on the electronic medication system were reviewed and met prescribing requirements. Medication charts had photo identification and allergy status notified. The GP had reviewed the medication charts three monthly. 'As required' medications had prescribed indications for use. The effectiveness of 'as required' medication had been recorded in the medication system.</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>	FA	<p>The food services are overseen by a qualified food service manager/chef. He is supported by an experienced cook and kitchenhands. All meals and baking are prepared and cooked on-site. All food services staff have completed food safety training. The Arvida four week rotating seasonal menu has been reviewed by the group dietitian. The main meal at midday offers two menu options. The cook receives resident dietary profiles and is notified of any dietary changes for residents including any weight loss. Dislikes and special dietary requirements are accommodated including food allergies, dairy free, gluten free, diabetic diets and pureed meals (using pure foods). The meals are prepared in the kitchen and transported in scan-boxes to the household kitchenettes. Food service staff plate meals in the households. There are snacks available for residents in the dementia care household 24/7.</p> <p>The food control plan expires 14 June 2022. Freezer, fridge and end-cooked foods, re-heating (as required), cooling, inward goods and dishwasher temperatures are taken and recorded daily. All perishable foods and dry goods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Chemicals were stored safely.</p> <p>Residents provide feedback on the meals through resident meetings (the chef attends) and resident surveys. The chef receives feedback directly both verbally and through resident meetings. Residents and relatives interviewed spoke positively about the choices and meals provided.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service</p>	PA Moderate	<p>Resident care plans on the resident electronic system for all resident files reviewed were resident focused and individualised, however not all support needs and interventions had been documented in the long-term care plans. There is documented evidence the resident (as appropriate) and relative are involved in the development of care plans. The involvement of allied health professionals involved in the care of residents were linked to the long-term</p>

<p>delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>care plans including physiotherapist, moving well coordinator, podiatrist, community mental health services, hospice, speech language therapist and occupational therapist.</p> <p>Paper-based short term care plans are used for short-term problems which are regularly reviewed by the RN; however, these are in a list format and not individualised. There is no record/history held on the individual resident record.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs are being well met. When a resident's condition alters, the registered nurse initiates a review and if required a GP or NP visit is arranged. Care plans and worklogs reflect the required health monitoring interventions for individual residents. A care activity worklog with scheduled tasks is generated for caregivers by the registered nurses. Monitoring charts including (but not limited to) repositioning, bowel chart, behaviour chart, food and fluid chart, fluid balance chart, weight, blood pressure monitoring, blood sugar levels, pain monitoring, neurological observations and toileting regime are utilised. Monitoring charts are well utilised. Family is notified of all changes to health and GP visits as evidenced in the electronic progress notes.</p> <p>Wound assessments, wound management plans with body maps, photos and wound measurements were reviewed on eCase. There were 21 wounds (skin tears, abrasions moisture associated skin conditions). There were five stage 1 pressure injuries on the day of the audit. Three were facility acquired and one resident had two community acquired pressure injuries. There is access to the district nursing service and DHB wound nurse specialists. Registered nurses interviewed stated there were adequate pressure injury resources/equipment available. Care staff have attended pressure injury prevention training in January 2021.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence products and wound care supplies.</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</p>	<p>FA</p>	<p>The service employs two fulltime qualified diversional therapists/wellness leaders and an activity assistant. One diversional therapist provides activities in the rest home/hospital and is supported in the afternoons by an activity assistant. They work Monday to Friday and alternate Saturdays. One diversional therapist provides activities in the memory care (dementia) suite Monday to Friday. Caregivers/wellness partners coordinate activities in the weekends. There are plentiful resources. A Moving Well Coordinator is involved in the resident exercise programme.</p> <p>There are two separate activity programmes, one for the dementia care household and one for the hospital and rest home. The programme aligns with the Arvida living well model and include activities around eating well, moving well, resting well, thinking well, and engaging well. There are some integrated activities where dementia care residents attend under supervision including church services and entertainment. Residents receive a copy of the</p>

<p>service.</p>		<p>activity programme which has the activities available each day that are also displayed on activity boards throughout the facility. The programme is resident focused with some activities being resident led. Some activities in the dementia care household are set with the flexibility to include impromptu activities. One-on-one activities occur such as individual walks, chats, cooking (with the mobile kitchen) and music for residents who are unable to participate in activities or choose not to be involved in group activities. There is a Men's shed and ladies' group, friendship groups, happy hours, daily exercise groups, quizzes and sing-a-long. Residents are encouraged to maintain community links. Families and visitors bring in their pets for pet therapy. There is a wheelchair van and regular scenic drives. Covid restrictions have disrupted the activity programme. Families and residents have Facetime.</p> <p>A resident leisure profile is completed soon after admission. Individual leisure plans were seen in resident electronic files. The younger person and resident under LTS-CHC has individual leisure plans that include their personal recreational preferences. The qualified diversional therapists/wellness leaders are involved in the six-monthly review with the RN.</p> <p>The service receives feedback and suggestions for the programme through resident household meetings and surveys. The residents and relatives interviewed were happy with the variety of activities provided. The service has quality initiatives in progress including making fridge magnets for community market stalls, doing ceramics and pottery in the men's shed and the use of aromatherapy.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes in the electronic resident files reviewed. Family is invited to attend the multidisciplinary review meeting which includes input from the physiotherapist, DT, caregivers, and GP. Case conference notes are kept on the electronic system. Evaluations reviewed, identified if the resident goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 12 April 2022. The maintenance person has been in the role six months and has carpentry/joinery experience. He works fulltime and is available on call for urgent facility matters. There is a maintenance logbook in each nurses' station and reception which is checked daily and signed off as repairs are completed. There is a planned maintenance schedule that includes resident equipment checks, calibration of clinical equipment and testing and tagging of electrical equipment. Hot water temperatures are checked monthly, and records evidenced these have been maintained below 45 degrees Celsius. There are preferred contractors available 24 hours for essential services. Resident rooms are refurbished as they become vacant.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids and for the use of hospital recliner</p>

<p>for their purpose.</p>		<p>chairs. Residents were observed moving freely around the areas with mobility aids. All 88 resident rooms are single occupancy. The external areas, courtyard and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>The dementia care household has secure access. There is free access to safe outdoor gardens and walking pathways.</p> <p>Registered nurses and care staff interviewed stated they have adequate equipment to safely deliver care for rest home, hospital level and dementia level of care residents.</p>
<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>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the infection register on the electronic data base. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. This data is monitored and analysed for trends monthly and annually. Infection control surveillance is discussed at facility meetings and meeting minutes are displayed for staff. Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives benchmarking feedback from support office. There have been no outbreaks since the previous audit. One resident was identified as having campylobacter, this resident was transferred to hospital. No other residents or staff were affected. This was reported to the public health team and documented appropriately.</p> <p>Covid-19 was prepared for with adequate supplies of personal protective equipment (PPE) sighted. Isolation kits are centrally located and easily accessible to staff. The staff interviewed were knowledgeable around isolation policies and protocols. Training and competencies were completed around hand hygiene and donning and doffing PPE. Education sessions around Covid-19 have been completed annually on the online platform.</p> <p>This audit was conducted under level 2 restrictions. All staff, visitors and contractors were required to wear masks while in the facility. All visitors and contractors were required to sign in and complete a wellness declaration in line with current guidelines.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. On the day of the audit there were no residents with any restraints and three residents using enablers (both bedrails). The files for the residents with enablers showed that enabler use was voluntary. Assessment, consent form and the use or risks associated with the enabler were evidenced in the resident files reviewed. Monitoring charts were maintained on the electronic system. Staff receive training on restraint minimisation and enabler use.</p>

minimised.		
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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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate,</p>	PA Low	<p>The quality, risk, restraint and infection control meetings, the health and safety meetings and six-monthly full facility meetings have been held monthly as scheduled, however the clinical, household meetings, resident meetings, and kitchen meetings were not evidenced as being held according to schedule. Meeting minutes were available for the meetings that have been held as scheduled, however not all meeting minutes could be located for meetings not held according to schedule. The meeting minutes sighted did not evidence discussions held with all staff regarding quality data collated including quality indicators and internal audit results and corrective actions. Staff confirmed there were no discussions held around this at the meetings.</p>	<p>1) Household meetings, kitchen meetings, clinical nursing meetings, were not evidenced as occurring as scheduled.</p> <p>2) Meeting minutes for unscheduled meetings could not be located</p> <p>3) Meeting minutes for the full facility meetings did not evidence discussions held around quality data, internal audits, and corrective actions.</p>	<p>1&2) Ensure meetings are held according to schedule and meeting minutes are maintained.</p> <p>3) Ensure meeting minutes evidence discussion with staff</p>

consumers.				around quality data. 90 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Long-term care plans for six residents (two hospital, two rest home and two dementia care) were reviewed. Care plans had been evaluated six-monthly, however not all support needs and interventions had been documented to meet resident goals. Short-term care plans are used for short-term problems and reviewed regularly, however these are not individualised but collated as a summary of all residents with short-term care plans.</p>	<p>1) a) The use and management of continuous oxygen via a concentrator for one hospital resident (including care of the equipment) was not included in the care plan, b) there were no documented supports/interventions for one resident with deteriorating mood requiring GP involvement and an interRAI re-assessment, c) there were no documented supports/intervention or de-escalation strategies including activities for two residents (one rest home and one dementia care) with known behaviours as described in their behaviour monitoring charts.</p> <p>2) Short-term care plans are in a resident list format and not held in the individual file therefor there is no record/history of problems.</p>	<p>1) Ensure care plans include current support and interventions to support resident needs.</p> <p>2) Ensure short-term care plans are integrated into the individual resident record.</p> <p>60 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.

No data to display

End of the report.