

# Queenstown Country Club Living Well Limited - Lake Wakatipu Care Centre

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## 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:

<b>Legal entity:</b>	Queenstown Country Club Living Well Limited
<b>Premises audited:</b>	Lake Wakatipu Care Centre
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 24 February 2022      End date: 25 February 2022
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	30



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Lake Wakatipu is part of the Arvida aged care residential group since May 2021. The service provides hospital (medical and geriatric) and rest home level of care for up to 35 residents. On the day of audit, there were 30 residents in total. The residents, relatives and general practitioner commented positively on the care and services provided at Lake Wakatipu Care Centre.

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

The Arvida policies, procedures, electronic management system, quality management system and Living Well model of care is being implemented. There is a business continuity plan reflecting risks related to Covid-19 and workforce shortages.

Internal improvements that have been made included new carpets, vinyl flooring and replacement of some furniture.

A village manager (non-clinical) is supported by a clinical manager (registered nurse) and living well manager (registered nurse). The management team have considerable experience in management of an aged care facility.

This audit identified shortfalls around meeting minutes and medicine management.

## 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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Staff at Lake Wakatipu 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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The quality and risk management programme includes service philosophy, goals, and a quality/business planner. Meetings are held to discuss quality and risk management processes. Residents/family meetings are held regularly, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Falls prevention strategies are in place that includes the analysis of falls incidents. An education and training programme has been implemented with a current training plan in place for 2022. Appropriate employment processes are adhered, a staff appraisal schedule is available for 2022. A roster provides appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. A sample of residents' files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan. Planned activities are appropriate to the resident groups. The residents and family interviewed confirmed satisfaction with the activities programme. Staff responsible for medication management have current medication competencies. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building does not currently have a warrant of fitness; however, a district council letter of compliance was sighted. Staff are provided with personal protective equipment. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. All bedrooms are single, and some have shared ensuite facilities. The outdoor areas are safe and easily

accessible. Housekeeping staff maintain a clean and tidy environment. Laundry and linen service is completed off site with personals completed on site.

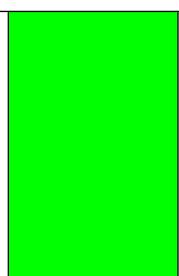
There is an approved evacuation scheme and sufficient emergency supplies for at least three days. A staff member trained in first aid is on duty at all times.

## 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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Restraint minimisation and safe practice policies and procedures are in place. At the time of audit, there were five residents using an enabler and no residents using restraint. The assessment, consent and review processes were completed for the enablers. Staff receive training in restraint minimisation and challenging behaviour management.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources

to inform the service providers. 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 and evaluated. A comprehensive Covid-19 response plan is documented and actioned.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	43	0	2	0	0	0
<b>Criteria</b>	0	91	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: 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 ten staff (three wellness partners [caregivers], two registered nurses [RNs], two enrolled nurses [ENs], one activities coordinator, one cook, one kitchen assistant) confirmed their familiarity with the Code. Interviews with seven residents (five rest home and two hospital) and three relatives (two hospital, one rest home) confirmed the services being provided are in line with the Code. The Code is discussed at resident, staff, and quality meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are policies around informed consent. Six resident files reviewed, (four at hospital level, and two at rest home level) included signed general consent forms. Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy in place.</p> <p>In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of residents' care. Admission agreements had been signed and sighted for all the files seen. Copies of EPOAs were on resident files where available.</p>

<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	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer and in each unit. 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. The service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the resident's family and chosen social networks.</p>
<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	<p>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 and family members interviewed confirmed that the service made an effort to maintain contact with relatives/family members when visiting could not occur during certain times of the Covid-19 response framework. Community links were evident within the examples provided. Residents are assisted to maximise their potential for self-help and to maintain links with whānau and the community by supporting them to go out into the community. The activities programme includes church services, entertainers, and volunteers (when permitted).</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. Three complaints in 2021 have been recorded and no complaints received for 2022 year to date.</p> <p>All complaints reviewed had been managed appropriately with acknowledgement, investigations and responses recorded. Residents and family members advised that they are aware of the complaints procedure and how to access forms. Complaints are discussed at staff meetings.</p> <p>One complaint was referred from Age Concern to the DHB in August 2021, the complaint has been followed up and closed off by the facility. There was evidence of a corrective action plan implemented, related to increase staff awareness through training in dignity and respect, palliative care principles and infection control practices.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The village manager, the clinical</p>

<p>Consumers are informed of their rights.</p>		<p>manager and RNs discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the monthly resident/family meetings lead by a representative from Age Concern. Three relatives (two hospital, one rest home) and seven residents (five rest home level including one ACC, and two hospital level of care) reported that the service is upholding the residents' rights. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.</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. A policy describes spiritual care. Church services are conducted regularly. Residents interviewed indicated that residents' spiritual needs are being met when required.</p> <p>The wellness partners interviewed reported that they knock on bedroom doors prior to entering and ensure doors are shut when cares are being given and do not hold personal discussions in public areas. All the residents interviewed confirmed that their privacy is being respected. Shared bathrooms and toilets have a privacy lock.</p> <p>Resident files reviewed identified that cultural and/or spiritual values and individual preferences were identified on admission with family involvement, and these were documented in the residents' care plan. This includes cultural, religious, social, and ethnic needs.</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>There is a Māori health plan and cultural safety policy to guide practice, including recognition of Māori values and beliefs and to identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are addressed in the care plan. Links are established with community representative groups as requested by the resident/family. Cultural training is provided for staff. There were no residents or staff identified as Māori at the time of the audit. Discussions with staff confirmed that they are aware of the need to respond to cultural differences and confirmed new residents' spiritual needs and their whānau cultural needs are met with respect and consideration.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	<p>FA</p>	<p>The residents' personal needs and values were identified on admission and this information was gathered from previous interRAI assessments and residents, family and/or enduring power of attorney (EPOA). All care plans reviewed included the resident's social, spiritual, cultural, and recreational needs. During interviews, staff described talking to residents during cares and getting to know what is important to them</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>and learning about different cultures and values. Wellness partners could describe how they meet the individual needs of residents. Staff receive training on cultural safety and awareness.</p>
<p>Standard 1.1.7: Discrimination 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. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics and code of conduct, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct and house rules.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</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>Lake Wakatipu has been proactive in implementing the Attitude of Living Well framework (model of care) since the transfer of ownership to Arvida. The model of care includes the five pillars (eating well, moving well, resting well, thinking well, and engaging well). The living well model is where the environment, staff and daily routines embrace a holistic approach to helping residents live their best life and stay connected with the community. Small groups of residents are supported within the care communities by decentralised self-led teams of employees that together create a home, nurture relationships, determine their own lives and build community. Residents are encouraged and supported to create a comfortable living space suited to their particular needs and personal tastes.</p> <p>The contracted medical practice ensures the general practitioner (GP) visits once a week or as needed. The hospital is co-located to the service. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. Physiotherapy services are provided on site, once a week. The service has links with the local community. Relatives interviewed spoke positively about the care and support provided.</p> <p>Arvida has contracted a Māori health consultant to support facilities establishing Māori community links. Arvida has an established quality and risk framework. The framework includes standardised policies; an education programme including core competencies for different staff groups; an internal audit and corrective action planning process; internal and external benchmarking; centralised management of high-risk complaints and mandatory reporting; and surveys (resident/relative and staff). The quality framework</p>

		<p>is being implemented at Lake Wakatipu apart from the meetings documentation (link 1.2.3.6).</p> <p>Arvida has a coordinated incident management system structure that ensures that resident and staff records are daily updated for easy contact tracing, as part of the Arvida Covid-19 preparedness plan.</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 alert staff to their responsibility to notify family/next of kin of any accident/incident. Full and frank open disclosure occurs. Incident/accidents forms reviewed had documented evidence of family notification or noted if family did not wish to be informed.</p> <p>Relatives interviewed confirmed that they are notified of any changes in their family member's health status. A residents' and household meeting occurs monthly. At this meeting previous outstanding items are discussed, an agenda is followed, food and activities are discussed, as well as general matters arising. There are weekly newsletters printed to update residents and relatives of current affairs. New staff are introduced, residents are informed about staff achievements, complaints and their resolutions, any planned improvements, or changes and any Covid-19 related information. Any issues arising from the meeting are communicated to staff and issues raised from these meetings are investigated by the village manager. There was evidence of implemented corrective actions. Interpreter services are available as required. There are no non-English speaking residents residing at Lake Wakatipu currently. Staff could describe interpreter services should this be necessary for any resident. Staff received education through the Altura online platform in communication related strategies for residents with hearing and speech impairments.</p> <p>Family members interviewed confirmed they feel informed about the facility's strategy under the Covid-19 preparedness framework.</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>Lake Wakatipu provides rest home and hospital (geriatric and medical) level care for up to 35 residents. All beds are dual-purpose. At the time of the audit there were 30 residents in total. There were nine rest home residents, including one resident on an ACC funded contract and 21 hospital residents, including one resident funded as a palliative care resident. All other residents were under the age-related residential care (ARRC) contract.</p> <p>Arvida took ownership of Lake Wakatipu Care Centre in May 2021.</p> <p>There is a village manager (non-clinical) with a business background, and he has been in the role since May 2021 and also oversees the operations of Queenstown Country Club Village (Arvida). A living well manager (RN) has recently been appointed to assist the village manager to oversee the operational</p>

		<p>matters of Lake Wakatipu Care Centre whilst the village manager is based at the nearby retirement village where a new care centre is being planned. They are supported by an experienced clinical manager who has worked as an RN with the previous owners and has been in this role since June 2021.</p> <p>The management team is supported by the wellness and care team.</p> <p>The village manager reports to the support office on a variety of operational issues and provides a monthly report to the chief executive officer (CEO). Arvida has an organisational business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Lake Wakatipu has a business plan for 2021–2022 that is due for review in May 2022. The village manager records achievements against these plans six monthly and are reviewed by the senior operations team at least annually.</p> <p>Regular meetings are held between the village manager and support office as well as weekly management meetings between the village manager, clinical manager, living well manager and designated RNs. The village manager and clinical manager have completed in excess of eight hours of professional development in the past twelve months. There is a scheduled plan for 2022 for professional development for the newly appointed living well manager.</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>	FA	<p>In the absence of the village manager, the living well manager is in charge. The living well manager covers the clinical manager if she is absent. Remote support is provided by the wellness and care team if required.</p> <p>The village manager is on call for building related matters and contacts external contractors if required.</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 an implemented quality and risk management system in place at Lake Wakatipu which is designed to monitor contractual and standards compliance. There is a 2021/2022 business/strategic plan that includes quality goals and risk management plans. The clinical manager is responsible for providing oversight of the quality and risk management system on site, which is also monitored at organisational level. Interviews with staff confirmed that there is discussion about quality data at staff meetings, however this could not always be evidenced through the meeting minutes reviewed. Arvida Group policies are reviewed at least every two years.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been</p>

		<p>completed for 2021 and being implemented for 2022. Areas of non-compliance identified through quality activities are actioned for improvement. All staff interviewed could describe the quality programme corrective action process. Restraint and enabler use (when used) is reported within combined staff and quality meetings.</p> <p>Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff, and families. The November 2021 resident/relative satisfaction survey results are not yet available from the independent survey agency. Resident/family and household meetings occur monthly where opportunities are created for feedback on all aspects of the service.</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 village manager at the combined monthly quality/staff meeting. There are also monthly national health and safety meetings conducted online.</p> <p>The village manager and clinical manager are part of the health and safety committee. Hazard identification forms and an up-to-date hazard register are in place through the electronic (Mango) system. WellNZ assist the service with the ACC Accredited Employers Programme and rehabilitation of injured employees. The service had weekly meetings during Covid-19 throughout the alert levels. The hazard register had been reviewed end of January 2021. 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. Staff complete manual transfer and hoist competencies.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A registered nurse (RN) conducts follow-up of residents. Ten incident forms reviewed for January 2022, demonstrated that appropriate follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for two unwitnessed falls.</p> <p>Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been three section 31 notifications completed since the last audit (three for physical aggression for the same resident in June 2021 and one for a missing resident in January 2022). There had been no outbreaks since May 2021 (when Arvida purchased the facility). There was evidence of toolbox meetings and debrief meetings following the essential notifications.</p> <p>The clinical manager and living well manager interviewed confirmed in light of the current workforce issues and Covid-19 environment, both had to cover shifts as an immediate remedy to cover RN</p>

		unavailability. Immediate actions were taken to remedy the situation by filling the shift with the clinical manager or living well manager. Risks were managed appropriately, and a section 31 was not required.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience, and veracity. Seven staff files were reviewed (one clinical manager [RN], two RNs, two wellness partners, one activities coordinator, one cook). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were scheduled for 2022. A copy of practising certificates is kept.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on the Altura online platform; support office keep a schedule of progress on orientation self-learning modules. Staff could describe the orientation programme and two new caregivers confirmed they felt supported through the process.</p> <p>The in-service education programme for 2021 has been completed and the plan for 2022 is being implemented. The village manager, clinical manager, living well manager and RNs are able to attend external training, including sessions provided by the district health board (DHB). There are six RNs, and four of them have completed interRAI training.</p> <p>Compulsory training modules also included dementia care related topics, palliative care, Covid-19, and outbreak management is completed through the Altura learning platform. Staff completed compulsory training sessions through scheduled face to face education sessions or through the Altura online training platform. Education includes clinical and non-clinical topics. The training programme is aimed at improving skills and knowledge related to aged care, to meet contractual requirements but also topics related to personal development including teamwork, conflict management and communication across cultural barriers. Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours plus of staff development or in-service education has been provided annually.</p> <p>There are 22 wellness partners in total with more than 50% having achieved either National Certificate level 4 or level 3. Competencies completed by staff included medication, insulin, wound care, manual handling, hand hygiene, syringe driver and restraint, correct use of personal protective equipment (PPE) and there was an up-to-date register. All RNs including the clinical manager and living well manager, activities coordinator and three wellness partners have a current first aid certificate on file.</p>
Standard 1.2.8: Service	FA	A policy is in place for determining staffing levels and skills mix for safe service delivery. Adequate RN

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>cover is provided 24 hours a day, 7 days a week. Sufficient staff are rostered to manage the care requirements of the residents. The service has a total of 48 staff in various roles. Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner. Wellness partners interviewed stated that management are supportive and approachable. Staff interviewed advised that staff might need to do double shifts to replace staff in case of sickness/absenteeism. The roster reviewed, evidenced all shifts are covered. Interviews with residents and family members confirmed there are sufficient staff to meet the needs of residents.</p> <p>The village manager interviewed confirmed staff turnover had been unavoidable and the service learned how to respond proactively with the workforce issues through allowing working of double shifts and increase RN shifts to 12 hours instead of eight.</p> <p>The village manager, clinical manager and living well manager work from Monday to Friday and are available on-call after hours. All beds in the facility are dual purpose. At the time of the audit there were 30 residents in total (nine rest home residents and 21 hospital residents).</p> <p>Registered nurses work 12-hour shifts Monday to Sunday (6.45 am-7.15 pm ,7 pm-7 am)</p> <p>There are two areas:</p> <p>Coronet (16 beds – 11 hospital residents and 4 rest home residents)</p> <p>Morning: 3x wellness partners work 6.45 am-3.15 pm.  Afternoon: Wellness partners x 2 work 2.45 pm-11.15 pm.</p> <p>Remarkables (19 beds - 10 hospital residents and 5 rest home residents)</p> <p>Morning: Wellness partners x 3 work 6.45 am-3.15 pm.  Afternoon: Wellness partners x 2 work 2.45 pm-11.15 pm.</p> <p>Night: One wellness partner works from 11 pm-7 am and one vacant role for a second caregiver.</p> <p>Activities coordinator (wellness leader) works 34 hours per week Monday- Friday.</p> <p>There are separate laundry (personal clothing only), household (cleaning) and kitchen staff.</p> <p>Cleaners currently work 3 days a week and an external contractor is used the other days of the week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	<p>FA</p>	<p>All relevant initial information was recorded within required timeframes into the resident's individual electronic record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access and are held electronically, accessible by password only. Care plans and notes are legible. All resident records</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>contain the name of resident and the person completing. Individual resident files demonstrated service integration including records from allied health professionals and specialists involved in the care of the resident.</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 are provided for families and residents prior to admission or on entry to the service. Seven admission agreements reviewed aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the clinical manager or living well manager are available to answer any questions regarding the admission process.</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 were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs, ENs and wellness partners) have been assessed for competency on an annual basis. Registered nurses have completed syringe driver training. Annual education has been provided around safe medication administration. The service uses an electronic medication charting and administration record system. There is documented evidence of medication reconciliation on delivery of medications. Medication fridges and medication storage room temperatures are checked daily. All eye drops and ointments were dated on opening. Standing orders are not used. Controlled drug medication is managed appropriately with exception to weekly checks. This is an area for improvement. There were no residents self-medicating on the day of audit.</p> <p>Medication charting is completed electronically by the GP. Twelve medication charts (eight hospital and four rest home) reviewed, had photo identification and allergy status recorded. All medication charts sighted were completed appropriately. Two medication rounds were observed, and the RNs completed the administration process correctly.</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>A kitchen manager oversees the onsite kitchen, and all meals are cooked on site. There is a seasonal four-week rotating menu, which is reviewed by a dietitian at organisational level. A resident nutritional profile is developed for each resident on admission which identifies dietary requirements and likes and dislikes, and this is provided to the kitchen staff by registered nurses. The kitchen is able to meet the needs of residents who require special diets, and the cook works closely with the registered nurses on duty. Special diets and likes and dislikes are readily visible on a whiteboard in the kitchen and are updated with any changes to match updated nutritional profiles. Special equipment such as lipped plates and adapted cutlery are available according to resident need. On the day of audit, meals were observed to be well presented. Supplements are provided to residents with identified weight loss issues. Additional snacks are available at all times.</p> <p>The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring 14 June 2023. Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing. End-cooked and serving temperatures are taken on each meal. Chiller and freezer temperatures are taken daily and are all within the acceptable range. Cleaning schedules are maintained. All foods were date labelled in the pantry, chiller, and freezers. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The clinical manager or an RN completes an initial assessment on admission including risk assessment tools. An interRAI assessment is undertaken within 21 days of admission and six monthly or earlier, due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summary were in place for the resident files reviewed. The long-term care plans in place reflected the outcome of the assessments and areas triggered were addressed in the care plans reviewed.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Resident care plans reviewed were resident focused, comprehensive, addressed the resident need and were integrated with other allied health services involved in resident care. Service integration was evidenced by documented input from a range of specialist care professionals, including the physiotherapist, speech and language therapist, dietitian, hospice, and mental health care team for older people. Relatives and residents interviewed all stated they were involved in the planning of resident care. In all files reviewed there was evidence of resident and relative involvement in care planning. Activity assessments were completed by the activities staff within three weeks of admission. Care plans reviewed provided evidence of individualised support. Short-term care plans are in use for short-term needs and changes in health status. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</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>When a resident's condition alters, the clinical manager or registered nurse initiates a review and if required, GP/nurse specialist consultation. There is documented evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits, referrals, and changes in medications. Discussions with families were recorded in the resident files reviewed.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound documentation was in place for six residents (one moisture associated skin damage, three skin tears, one excoriation under breast, and one scalp laceration). There were two residents with pressure injuries. One with a stage two heel blister, and one with a sacral pressure injury. Wound documentation was reviewed for the two pressure injuries which showed ongoing assessments. Pressure relieving equipment was in use.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>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. Monitoring occurs for weight, vital signs, blood glucose, and pain, challenging behaviour, food, and fluid input charts.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>The service employs an activity coordinator who has a level 4 caregiver qualification and is also completing diversional therapist qualifications. The staff member has been in the role for two years and works 34 hours per week. There are regular set activities including themes and events which are added</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>to in order to individualise activities to resident need and preferences within the facility, including craft, newspaper reading, music, pet therapy, exercises, church services, and shopping. A weekly activities calendar is distributed to residents, posted on noticeboards and is available in large print. On the days of audit residents were observed participating in activities within the two resident areas set up due to Covid-19 restrictions. The activities coordinator seeks verbal feedback on activities from residents and families to evaluate the effectiveness of the activity programme, enabling further adaptation if required. Residents interviewed were positive about the activity programme.</p> <p>Those residents who prefer to not to participate in communal activities receive one-on-one visits and individualised activities according to their preferences.</p> <p>Residents interviewed stated their satisfaction with the activities provided and complimented the members of the activities team.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long term care plans are evaluated by the RNs six monthly or earlier if there a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six monthly multi-disciplinary review (MDR) is also completed by the registered nurse with input from caregivers, the GP, the activities coordinator, resident and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation, or if needs change (ie, short-term changes). Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. These are evaluated at regular intervals.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referrals to other health and disability services were evident in the sample group of residents' files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. Examples of referrals sighted were to occupational therapist, physiotherapy, dietitian, mental health services, speech language therapist, community mental health nurse, and hospital specialists. Discussions with the clinical manager and two registered nurses identified that the service has access to GPs, ambulance/emergency services, allied health, dietitians, physiotherapy, continence and wound specialists, and social workers. The local hospital including an emergency department is located within the same building which is accessed via ambulance call out. Afterhours on call cover is accessed through telehealth to a GP virtual service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous</p>	<p>FA</p>	<p>There are policies and documented processes regarding chemical safety and waste disposal in place. All chemicals were clearly labelled with manufacturers' labels and stored in locked areas. Safety datasheets</p>

<p>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>		<p>and product sheets are available and readily accessible for staff. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff and were seen to be worn by staff when carrying out their duties on the day of audit. A spills kit is available.</p> <p>There are two sluice rooms in the facility (one on Coronet with a sanitiser and one smaller one in Remarkables). Both sluice rooms were clean, well-organised, and have separate handwashing facilities and hand sanitisers. Personal protective equipment is available in the sluice room.</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>	<p>FA</p>	<p>The building holds a current building system status issued by the local district council in lieu of a building warrant of fitness, issued January 2022. The building is part of the local hospital building and therefore is the responsibility of the hospital to provide a building warrant of fitness. A request book for repairs is maintained and signed off as repairs are completed. There is a part-time maintenance contractor who carries out the 52-week planned maintenance programme. The maintenance contractor is also on call after hours for urgent matters. The checking and calibration of medical equipment including hoists, has been completed annually and is next due August 2022. All electrical equipment has been tested and tagged in November 2021. Hot water temperatures have been tested and recorded monthly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7.</p> <p>The Village Manager advised that they have a programme of repairs and maintenance to be completed. The service has replaced lino in one bathroom, replaced the entire call bell system and are working their way through painting and refurbishment of resident rooms. The facility looked clean and tidy, and no immediate hazards were noted. There is an issue with getting product and materials at present due to labour shortages and supplies (due to Covid). The village manager has a workplace inspection list that he is working through as able.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required. There is outdoor furniture and seating with shade in place, and there is safe access to all communal areas. The external areas are landscaped and accessible.</p> <p>The wellness partners and RNs interviewed stated that they have all the equipment required to provide the care documented in the care plans.</p>
<p>Standard 1.4.3: Toilet, Shower,</p>	<p>FA</p>	<p>Six resident rooms have shared ensuites. There are three communal showers, one bathroom and six</p>

<p>And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>communal toilets throughout the facility. Resident rooms have hand basins. Visual inspection evidenced toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors, and wall surfaces are constructed from materials that can be easily cleaned. Handrails are appropriately placed in ensuite bathrooms, communal showers, and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Residents interviewed reported their privacy is maintained at all times.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility equipment. Residents are encouraged to personalise their bedrooms with personal belongings as viewed on the day of audit. Staff interviewed reported that they have more than adequate space to provide care to residents. Gloves are available for staff in resident rooms. All rooms have free flowing soap and paper handtowels.</p>
<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>	FA	<p>There are large and small communal areas. The service has divided the facility into the two wings and staff and residents are kept separate during the current stage of the Covid-19 pandemic and with numerous community cases. Each wing has a dining room and a lounge area as well as access to outside courtyards and gardens. Activities occur in all lounges and dining areas which are large enough to cater for the activities on offer, are accessible and can accommodate the equipment required for the residents. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The lounge and dining areas are spacious, inviting, and appropriate for the needs of the residents. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance during the audit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The majority of laundry is undertaken off site twice a week or more when required, with only personal clothing being washed in the small, well organised laundry. The laundry is divided into a "dirty" and "clean" area and staff could describe how this is managed. There is a comprehensive laundry manual; cleaning and laundry services are monitored throughout the internal auditing system and the resident satisfaction surveys.</p> <p>There is a cleaning manual available. The cleaners' equipment was attended at all times or locked away</p>

		<p>in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. Sluice rooms were kept locked when not in use. Cleaning products are colour coded (eg, mop heads for each area). All floors/wall coverings were intact and able to be hygienically cleaned. Personal protective equipment is available in the laundry, cleaning, and sluice room. Staff were observed to be wearing appropriate protective wear when carrying out their duties.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food, and supplies (torches, radio, and batteries), emergency power and barbeque. The service has alternative gas facilities for cooking in the event of a power failure, with a back-up system for emergency lighting including a back-up generator. There is 2000 litres of water stored on site.</p> <p>Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. Smoke alarms, a sprinkler system, evacuation notices and exit signs are in place.</p> <p>The civil defence kit is checked monthly. There is sufficient water stored to ensure for three litres per day for three days per resident stored in an external tank. Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on staff pagers and also give an audible alert. There is an escalation system in place that alerts management, should call bells ring for extended periods. Residents have call bells within reach (sighted) and this was confirmed during resident and relative interviews.</p> <p>The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. Access by public is limited to the main entrance. Covid-19 sign-in is mandatory for visitors and staff.</p> <p>Security policies and procedures are documented and implemented by staff. The buildings are secure at night.</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</p>	FA	<p>All bedrooms and communal areas are appropriately heated, have ample natural light and ventilation. The facility has central heating that is thermostatically controlled. Additional large panel heaters are in use in the lounges. Staff and residents interviewed, stated that this is effective. All bedrooms and communal areas have at least one external window. There is one monitored outdoor area where residents may smoke. All other areas are smoke free.</p>

comfortable temperature.		
<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. The Living well manager (RN) and enrolled nurse are the designated infection control coordinators (ICC) with support from the clinical manager and Arvida infection control team. Both are scheduled for infection control training at the DHB, however completed all Altura online training related to infection control and Covid-19 modules. Minutes are available for staff (link 1.2.3.6). Internal audits have been conducted and include hand hygiene and infection control practices. The Arvida infection control programme has been reviewed annually.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza and Covid-19 vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The living well manager (registered nurse) and enrolled nurse are the designated infection control (IC) coordinators. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator have external support from the Arvida Group support office and the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction.</p> <p>The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the Arvida support office.</p> <p>Hand washing facilities are available throughout the facility (including sluice rooms), flowing soap and alcohol hand gel is freely available. Staff were observed practising good hand hygiene.</p> <p>The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or have been in contact with infectious diseases. Covid-19 preparedness framework is integrated in all levels of the infection control plan.</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</p>	FA	<p>Lake Wakatipu uses the Arvida group infection control policies and procedures. The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Policies include Covid-19 preparedness, guidelines specific to different alert levels and cleaning procedures include reusable eyewear and cleaning between equipment use.</p>

<p>requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</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. Education is provided for all new staff on orientation and Covid-19 education has been provided for all staff, including hand hygiene and use of personal protective equipment (PPE).</p> <p>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.</p> <p>The infection control coordinators have access to the Arvida intranet with resources, guidelines best practice, education packages and group benchmarking. The ICCs has also completed infection control audits.</p> <p>Resident education occurs as part of providing daily cares and as applicable at resident meetings.</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. Meeting minutes are displayed for staff (link 1.2.3.6). Internal infection control audits are completed with corrective actions for areas of improvement. The service receives benchmarking feedback from support office.</p> <p>An organisational Covid-19 strategy and pandemic plan was available to staff on site with links to education and associated resources relating to hand hygiene, PPE, and donning/doffing procedures. Covid-19 education was also provided for all residents, including hand hygiene and use of PPE; these details being passed on to families via email, telephone and in writing. During Covid lockdown the service implemented weekly staff briefings which allowed for updates, education, and discussion. All visitors are required to sign in, provide contact tracing information and show a vaccine passport on entry. Staff are still strongly encouraged to change uniforms. Staff and residents cohort in two 'bubbles' within the facility. The service utilise rapid antigen testing (RAT) as part of surveillance and risk management in line with</p>

		<p>increase of Omicron cases in the community.</p> <p>There have been no other outbreaks since May 2021.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. At the time of the audit there were five residents using enablers: four with bedrails and one with a low-low bed. Consent, assessments, care planning and reviews have been conducted as per Arvida policy and procedures.</p> <p>Staff receive training on restraint minimisation, which includes testing their competency. The wellness partners interviewed were able to describe the difference between an enabler and a restraint.</p>

## 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, consumers.</p>	PA Low	<p>The service uses an electronic resident management system. Infections are entered into each resident infection register and data is easily extracted for review, analysis, and trends. There is a manager review and summary entered at the end of each month on the electronic system. Benchmark data is sent to the facility each month from Arvida support office. Meeting minutes for 2021/2022 reviewed, showed inconsistent communication of all data related to infections. Handover notes include information regarding each resident infection status including two residents with an extended spectrum beta-lactamase (ESBL) infection.</p>	<p>Not all infection data, analysis, trends, benchmarking, and summaries are evidenced as being discussed in staff meetings.</p>	<p>Ensure there is documented evidence that staff are made aware of quality data, analysis, trends, benchmarking, and summaries related to infections.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>Medications are stored securely in two medication/treatment rooms. As the facility has split the resident areas into two wings to maintain safe bubbles during Covid, there are two rooms designated for medication storage. The service has two medication trollies. Medications are managed correctly with no expired medications evident on the days of audit. The medication fridge temperatures are monitored and recorded daily, and these were evident to be between 2-8 degrees Celsius. The medication storage room temperatures are also monitored, and this is recorded daily. Controlled drug registers were reviewed from both medication rooms. Weekly checks have not been conducted during the month of February.</p>	<p>Controlled drug register checks have not been conducted weekly as per requirements.</p>	<p>Provide evidence that weekly controlled drug register checks are undertaken.</p> <p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.