

The Wood Lifecare (2007) Limited - The Wood Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	The Wood Lifecare (2007) Limited
Premises audited:	The Wood Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 August 2019 End date: 28 August 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	83

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
	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

The Wood Lifecare is owned and operated by the Arvida Group. The service provides rest home and hospital level care for up to 112 residents. On the day of the audit there were 83 residents.

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

The village manager (RN) has been in the role since May 2017. He is supported by a clinical manager who has been in the position for 18 months and two clinical nurse leaders. The village manager reports to an executive partner (the CFO) on a variety of operational issues and provides a monthly report.

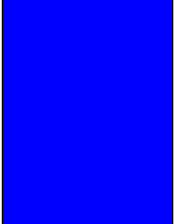
There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

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

Improvements have been identified around assessments, timeframes, self-medicating, restraint evaluation and infection control.


The service has been awarded continuous improvement ratings around, community involvement and the activities.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Staff strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). The service promotes the attitude of living well (wellness) and introduction of the household model. Residents' cultural needs are met. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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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 is being implemented and includes competencies. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. InterRAI assessments are utilised and link to care plans. Resident files included medical notes by the general practitioner and visiting allied health professionals.

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

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The Wood Lifecare has a current building warrant of fitness. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. There have been refurbishments completed throughout the facility. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised.

Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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The Wood has restraint minimisation and safe practice policies and procedures in place. At the time of the audit, there were three residents with restraints, and six residents using enablers. Enabler use is voluntary, and a consent is documented where enablers have been requested. Assessed risks are documented in care plans. Ongoing restraint assessments and monitoring occurs. Staff receive training around restraint minimisation and enablers.

Infection prevention and control

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	43	0	5	0	0	0
Criteria	2	94	0	5	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (eight caregivers, two registered nurses, two clinical leads, one enrolled nurse, two diversional therapists and one physiotherapist) confirmed their familiarity with the Code. Interviews with 12 residents (six rest home, six hospital) and four relatives (two rest home and two hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident, staff and community well-being 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>Informed consent processes were discussed with residents (as appropriate) and families on admission. Written general and specific consents were evident in the long-term resident files reviewed. Caregivers and RNs interviewed confirmed consent is obtained when delivering cares. Advance directives identified the resident resuscitation status. Advance directives and medically initiated 'do not resuscitate' had been appropriately signed by the resident and general practitioner (GP). Copies of EPOA are contained within the resident file where appropriate. Discussion with four relatives (two rest home, two hospital) identified that the service actively involves them in decisions that affect their relative's lives. A sample of ten resident files were reviewed. Signed admission agreements were sighted in the long-term resident files reviewed. General consents were also included as part of the admission agreement.</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. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.</p> <p>The service has established five resident advocates who provided training to staff in each of the Arvida Living Well pillars (Moving Well, Eating Well, Thinking Well, Resting Well, Engaging Well). These resident advocates support residents where needed.</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>	CI	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time. The service has exceeded the required standard around encouraging engagement with the community.</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. Six complaints (2018), have been received at The Wood since the last audit. The 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.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The information pack provided to residents on entry includes information on how to make a complaint, and information on advocacy services and the Code. This information has been discussed with residents and/or family members on entry to the service. Large print posters of the Code and advocacy information are displayed in the facility. The admission agreement includes information around the scope of services, and any liability for payment for items not included in the scope and the Code.</p> <p>Resident meetings provide the opportunity to raise issues/concerns. The Community well-being meeting run by residents also provides an opportunity to discuss consumer rights. The facility manager, the clinical manager and clinical leads interviewed described discussing the information pack with residents</p>

		and family members on admission.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting 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>Eight caregivers 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.</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>The 2019 satisfaction resident/relative survey identified a 96% outcome around respectfulness.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is a Māori health plan and cultural safety policy to guide practice, including recognition of Māori values and beliefs and 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 electronic care plan. Links are established with community representative groups as requested by the resident/family. Cultural training is provided for staff. One resident identified as Māori at the time of the audit. The resident interviewed was very happy with the care and support provided including being able to attend the marae. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<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 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 and learning about different cultures and values. Caregivers can describe how they meet the individual needs of residents. Staff receive training on cultural safety/awareness.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The facility has a staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures, and a staff training programme which covers all aspects of service delivery. Internal auditing programmes are implemented.</p> <p>External specialists such as wound care specialists, dietitian and continence nurse are used where appropriate.</p> <p>There is an Arvida-wide benchmarking programme, monitoring against clinical indicators were undertaken against all sites. There is an active culture of ongoing staff development with the Careerforce programme and Altura online training being implemented.</p> <p>There are implemented competencies for caregivers and RNs. There are clear ethical and professional standards and boundaries within job descriptions.</p> <p>The service has policies to guide practice that aligns with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p> <p>The service has established five resident advocates who provided training to staff in each of the Arvida Living Well pillars (Moving Well, Eating Well, Thinking Well, Resting Well, Engaging Well). These resident advocates spend time with new staff, which is now part of the staff induction and orientation. They also support residents where needed. Interviews with one of the advocates confirmed involvement in the service and working alongside staff and management to provide a resident-centred home.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	<p>FA</p>	<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.</p> <p>Twenty-one incident/accidents (from July 2019 across all areas) were reviewed on the eCase incident</p>

communication.		<p>register, overall, they had documented evidence of family notification where required. Progress notes also identified family communication.</p> <p>Relatives interviewed confirmed that they are notified of any changes in their family member's health status. A community wellness meeting occurs monthly. At this meeting previous meetings are discussed, agenda is followed, time spent on "general business" food and activities are discussed, as well as matters arising from residents.</p> <p>Interpreter services are available as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The Wood Lifecare is owned and operated by the Arvida Group. The service provides care for up to 112 residents across 32 rest home beds, 46 hospital level beds (including six dual-purpose beds) and 34 serviced apartments certified to provide rest home level care. On the day of the audit there were 83 residents in total; 39 rest home residents including two residents on respite, 36 hospital residents including one YPD resident, one resident on ACC contract and two residents on respite. There are six dual-purpose beds in the hospital area for either rest home or hospital level. There were eight rest home residents in the serviced apartments. All other residents were admitted under the aged related residential care (ARRC) contract.</p> <p>The village manager (RN) has been in the role since May 2017. He is supported by a clinical manager who has been in the position for 18 months and two clinical nurse leaders. The village manager and clinical manager are supported by their Executive Partner (CFO), general manager wellness and a national quality manager (who was available during the audit). The village manager reports to the Executive Partner (CFO), on a variety of operational issues and provides a monthly report.</p> <p>Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. The Wood Lifecare has a business plan for 2019–2020. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually. Regular meetings are held between the village manager and head office.</p> <p>The village manager and clinical manager have completed in excess of eight hours of professional development in the past 12 months.</p> <p>Staff, residents and relatives commented positively around the support and communication provided by the management team.</p>
Standard 1.2.2: Service Management	FA	<p>In the absence of the village manager, the clinical manager is in charge. Support is also provided by the executive partner (CFO), the general manager wellness and care, and the care staff.</p>

<p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a 2019 business/strategic plan that includes strategies for The Wood that link to the overall Arvida goals/strategies. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager and clinical manager are responsible for providing oversight of the quality programme, which is also monitored at an organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. Arvida Group policies are reviewed at least every two years across the group. Head office upload the new/updated policies on the Arvida intranet for staff to read. The service policies and processes meet relevant standards and links to their electronic system.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule is being completed. Areas of non-compliance identified through quality activities are actioned for improvement. The eCase electronic system alerts staff to residents' change in condition, for example weight loss, resulting in early awareness and management to prevent further decline. Staff interviewed could describe the quality programme corrective action process.</p> <p>There are various meetings across the village including (but not limited to) monthly RN meetings (overall quality committee), monthly staff meetings, monthly head of department meetings, monthly H&S meeting, and monthly community and wellbeing meetings. Quality data is shared and is reported through all relevant meetings. Corrective actions identified are shared with staff through meetings, message board on eCase and reports.</p> <p>The service has linked the complaints process with its quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. The monthly manager reports include complaints.</p> <p>Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. A resident/relative satisfaction survey was completed in March 2019. Corrective actions have been established in areas where improvements were identified. The net promoter score between the 2018 and 2019 survey increased. A number of residents attend the H&S committee meeting. As well as the monthly community and wellbeing meeting that residents attend there is a quarterly resident/family meeting.</p> <p>The service has a health and safety management system that is regularly reviewed. Risk management,</p>

		<p>hazard control and emergency policies and procedures are being implemented and are monitored by the Health and Safety Committee that meets monthly. The DT is the health and safety officer and is supported by eight H&S reps who have all completed external training. Hazard identification forms and an up-to-date hazard register is in place which is regularly reviewed at the H&S meeting. Falls prevention strategies are implemented including identifying residents at higher risk of falling and the identification of interventions on a case-by-case basis to minimise future falls. One resident has the role of 'moving advocate' and supports and encourages residents with exercises.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at meetings. A registered nurse (RN) conducts clinical follow-up of residents. Twenty-one incident/accidents (from July 2019 across all areas) were reviewed and demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for any unwitnessed falls. A monthly analysis is completed by the clinical manager.</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 have been section 31 incident notifications completed as required. There have been two deaths referred to the coroners. Both continue to be open with the coroner. The clinical manager completed a thorough investigation into the care of both residents and the time of the incidents. Recommendations for improvement around documentation have been identified and implemented by the service as a result of the investigations.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Ten staff files were reviewed (one clinical manager, three RNs, three caregivers, one diversional therapist, cook, and the maintenance person). There is evidence that reference checks were completed before employment was offered. Residents are involved on interview panels when interviewing for new staff. Annual staff appraisals were evident in all staff files reviewed. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The service has introduced a one-day induction and a minimum of three days orientation for all new staff that provides new staff with relevant information for safe work practice.</p> <p>Completed orientation is on files, and staff described the orientation programme. The in-service education programme for 2018 and 2019 (YTD) has been completed and self-directed learning sessions</p>

		<p>online through Altura are also being completed. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the district health board (DHB). 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. At least half of caregivers employed at The Wood have completed either level 2, 3 or 4 Careerforce. There are 16 RNs and 2 enrolled nurses, overall 6 of the RNs have completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The Wood Lifecare policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 117 staff in various roles including casual staff. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager and clinical manager work 40 hours per week from Monday to Friday and are available on call after hours. In addition to the village manager and clinical manager there are two clinical nurse leaders (one for the rest home and one for the hospital). There is at least one RN on at any one time. Extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirmed there are sufficient staff to meet the needs of residents. The caregivers interviewed stated that they have sufficient staffing levels.</p> <p>In the hospital area (36 hospital residents and 3 rest home residents), there is one clinical nurse leader and two RNs on duty on the morning shift, two RNs on the afternoon shift, and one RN on night shift. They are supported by ten caregivers (six long and four short shifts) on the morning shift, eight caregivers (three long and five short shifts) on the afternoon shift and two caregivers on the night shift.</p> <p>In the rest home area (36 rest home residents), there is one clinical nurse leader and one RN Wednesday to Sunday and an enrolled nurse Monday to Friday and one RN on the afternoon shift. They are supported by six caregivers (three long and three short shifts) on the morning shift, four caregivers (two long and two short shifts) on the afternoon shift and two caregivers on the night shift.</p> <p>The serviced apartments (eight rest home residents) have a separate roster with one caregiver on duty on the morning shift and one caregiver on duty on the afternoon shift. The rest home staff supervise the rest home level care residents in serviced apartments after 9.30 pm.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations and password protected on computers. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible and dated by the relevant caregiver or RN. Electronic records</p>

<p>identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>are integrated and include input from GPs and allied health.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services for rest home and hospital level care, are provided for relatives and residents prior to admission or on entry to the service. All admission agreements reviewed (for long-term residents) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. Planned exits, discharges or transfers were coordinated in collaboration with the resident and relatives to ensure continuity of care. The residents and relatives are involved for all exit or discharges to and from the service. Registered nurses interviewed could describe the processes of transferring residents to hospital, and the accompanying documentation required.</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, enrolled nurses and senior caregivers) have been assessed for competency on an annual basis. Annual education around safe medication administration has been provided. Registered nurses complete syringe driver training.</p> <p>The Wood Lifecare have one centrally located treatment room where all medications are stored. The medication fridge is checked daily and maintained within the acceptable temperature range. All eye drops, and ointments sighted were dated on opening. The service uses four-weekly delivery of robotic packs that are checked against the medication charts by the RNs and either one enrolled nurse or one medicine competent caregiver.</p> <p>There are two controlled drug registers in place, one for each service level. Weekly checks had been occurring in the rest home register, but not always conducted on a weekly basis in the hospital register. This had been identified by the clinical nurse leader, prior to the audit, and this had been rectified in the last few weeks.</p> <p>Twenty medication charts were reviewed across the rest home/hospital and serviced apartments. All had photo identification and had been reviewed by the GP at least three-monthly. 'As required' medication had indications for use. There was a shortfall around competencies for a self-medicating</p>

		resident.
<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 Wood Lifecare has a centrally located commercial kitchen where all food is prepared and served. There is a team of 16 kitchen staff including three cooks. All have completed food safety certificates. The cook interviewed explained the procurement of the food and management of the kitchen. The service has a verified food control plan 14 June 2020.</p> <p>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. Kitchen fridge, food, freezer, chiller and dishwasher temperatures were monitored and documented daily and were within safe limits.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. Special diets were noted on the kitchen noticeboard. The kitchen staff were knowledgeable of residents with weight loss and likes and dislikes of residents.</p> <p>The menu is a four-weekly seasonal menu which has been reviewed by the dietitian in March 2019. Dietary supplements are available.</p> <p>There is a total of five satellite kitchens throughout the facility, fridge temperatures were checked and within ranges, and cleaning schedules were maintained for each kitchenette area. Photos of each meal is laminated and made into a booklet for kitchenhands servicing food to refer to for presentation of meals.</p> <p>Food is served directly through the serving hatch from the bain maries in the main kitchen to the large dining room. Food is covered and transported in bain maries to the serviced apartment kitchenette and to the CCW satellite kitchen.</p> <p>The cooks attend the wellness meetings. Residents' can choose to have their meals in their rooms and that is resident choice. Residents and relatives interviewed, commented positively on the meals.</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,</p>	FA	<p>The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>

where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	There was a suite of assessment tools available in the electronic system. The RN completes an initial assessment on admission including risk assessment tools. A long-term care plan is completed and reviewed thereafter six-monthly, or earlier due to health changes. All long-term resident files reviewed identified interRAI assessment notes and summaries were available (link 1.3.3.3). Falls risk assessments were not always completed as per policy. The outcomes of assessment tools are linked to the long-term care plan. The resident needs, goals and supports are documented in the long-term care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident electronic care plans reviewed were overall resident-focused and individualised. A range of assessments including interRAI have been completed and linked to care plan interventions. All long-term care plans evidenced updates to care plans as changes to resident's health occurred. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. There was evidence of allied health care professionals involved in the care of the resident including the GP, physiotherapist, mental health team, podiatrist, hospice and dietitian. Relatives interviewed confirmed they were involved in the care planning process.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>When a resident's condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence in the electronic file that evidences family were notified of any changes to their relative's health including (but not limited to): accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Pain charts were in use for residents on PRN pain control medication.</p> <p>There has been increased nurse specialist support through referral to Older Persons Mental Health Nurse specialist and the Wound Nurse Specialist.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. On the day of the audit, twelve rest home residents and ten hospital residents had wounds. These were a mixture of skin tears, abrasions, and chronic venous ulcers. There were no residents with a surgical wound and drain. A sample of charts were reviewed. All had wound assessments, plans and the evaluations documented progression or deterioration of the wound. Photos were taken at regular intervals. The wound care nurse specialist has been involved with wounds as required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if</p>

		<p>weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. There is dietitian involvement where required.</p> <p>Monitoring occurs for weight, blood pressure, blood sugar levels, pain, neurological observations, food and fluid charts. These were sighted across the files reviewed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The service employs two activity staff who are both qualified diversional therapists (DT). There are activities scheduled across five days. The DTs rotate their time between the rest home and continuous care wing (CCW). The diversional therapists complete an activity profile/assessment on admission and develop/have input into two sections of the electronic care plan 'in leisure and pastoral care'.</p> <p>The Wood Lifecare has implemented the wellness/household model. The wellness/household model focuses on the relationship between the care team and the resident as partners in the pursuit of a rich and meaningful life. There is a wellness meeting and a resident delegate attends. The introduction of the wellness meeting has empowered residents into how the facility should be run and they provide feedback in the activity programme. There is a resident representative for each pillar of the model, and a resident representative attends the health and safety meetings. The community and wellness meetings are held monthly, the resident meetings are separated for the rest home/serviced apartments residents and the residents in CCW. These are held bi-monthly.</p> <p>There are activities on offer in both the rest home area and the residents can choose which they attend. The DTs try to run the activities programme as one rather than separate entities. Activities in the CCW are more one on one activities and focused more on advanced needs. The weekly planner is available on the noticeboards around the facility, there is a copy in each resident's room and apartment, and a reminder comes through the loudspeaker inviting residents to attend the activities in the activities lounge. Activities for residents to attend include, crafts, board games, card games, newspaper reading, cultural activities, exercises indoors and outdoors and bowls. There are two different planners that go up on the noticeboards in all areas and residents also get an individual copy. There were photographs on display of a recent dinner that was held at The Wood as residents identified they had no occasions to "get dressed up" anymore. The manager and clinical manager were in formal dress greeting residents coming in the door for their dinner. The dinner was enjoyed by all.</p> <p>There are a number of one-on-one activities for residents not involved in group activities. There is a van that goes out regularly and includes outings to the movies, shopping trips, and picnics in the park. The residents put their suggestions forward and the DTs accommodate this as much as possible (weather dependant).</p> <p>Community visitors to the facility include (but are not limited to) entertainers and guest speakers, pet connect and regular interdenominational and Catholic church services. Rest home residents in the</p>

		<p>serviced apartments are invited to participate in the activities in the care centre. Individual leisure activity plans were seen in all resident files reviewed. The service receives feedback and suggestions for the programme through resident meetings and surveys. Residents interviewed were happy with the activity programme. The service has exceeded expectations with their one on one activities initiative in the CCW.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>InterRAI re-assessments have been completed six-monthly in support of reviewing the care plan. Each section of the care plan is evaluated as care needs change and six-monthly. Written evaluations are documented and show progression towards goals in the care plan evaluation section.</p> <p>Relatives are invited to attend the six-monthly MDT review and informed of any changes if unable to attend. The MDT meeting (now called Case Conference checklist on the electronic system) includes a holistic evaluation of care and support including input from allied health and medical staff. 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 and long-term care plans are updated to reflect changes. Short-term care plans are not used. Changes to the electronic long-term care plan identify name and date to reflect the update. Residents and relatives interviewed confirmed involvement in the Case Conference and evaluation of the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The RNs discuss referrals with the GP and facilitates access to other medical and non-medical services. Referral to other health and disability services is evident in the resident files sampled. Referral documentation is maintained on resident files. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place. Safety datasheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored safely and were secure throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training. There is a secure sluice room in the rest home and hospital wings. Spill kits are set up for use when needed.</p>

waste, infectious or hazardous substances, generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 4 August 2020. The service employs a full-time maintenance person who is on call 24/7 for any maintenance issues. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained that includes internal and external building maintenance. An external contractor completes annual calibration, electrical testing, and functional checks of medical equipment.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver resident cares. Hot water temperatures in resident areas are monitored and maintained below 45 degrees Celsius. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to mobilise safely within the facility. There is a lift between floors which is large enough for a stretcher as needed.</p> <p>There have been extensive renovations at The Wood, with all communal areas getting fireplaces installed and small kitchenette areas for residents to enjoy. Access to tea and coffee at all times is now available for resident and relatives to enjoy together. New brightly coloured coordinated furniture has been purchased and is suitable for all residents and meets infection control standards. There are several quiet seating areas throughout the facility. All areas are spacious, and easily accessible for residents using mobility aids. Renovations of resident rooms are continuing as these become available.</p> <p>The exterior has been upgraded to provide courtyards with water features, safe paving, outdoor shaded seating under the trees and gardens. There is a centrally located petanque courtyard which is easily accessible to all residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All resident rooms in the care centre on the ground floor have ensuites. A number of rest home rooms have shower ensuite facilities. There are also spacious communal shower rooms available. Communal toilets are located closely to communal areas. All serviced apartments on the first floor have a full ensuite. Toilet and shower facilities are of an appropriate design to meet the needs of the residents. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant and locks are on doors.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single and personalised. The care centre is designed in five wings (households) including the serviced apartments. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents rooms were personalised to individual tastes. Residents and relatives interviewed commented they were encouraged to personalise resident rooms.</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 is a large communal lounge and smaller lounges/sitting areas in each wing for quieter activities and visitors, to give more of a smaller household feel. There is a large main dining room, and activities room and a smaller dining area in the rest home wing. There is also an open plan dining area for the serviced apartment residents including rest home residents on the 1st floor. There is a large dining room and small lounge with a kitchenette area, and a large communal lounge/dining area also used for activities in the hospital (CCW).</p> <p>Seating and space in all lounges are arranged to allow both individual and group activities to occur. All communal areas are easily accessible for residents to assist using mobility aids or with staff assistance.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry staff seven days a week. There are defined clean/dirty areas in the laundry with an entry and exit door. Internal and external audits monitor the effectiveness of the cleaning and laundry processes. Dirty laundry trolleys in the wings are covered. The cleaning trolleys are well equipped and stored safely when not in use. Residents and family interviewed, reported satisfaction with the cleaning and laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency and disaster management plan in place to ensure health, civil defence and other emergencies are included. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 26 July 2019. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. There is a dedicated centrally located room which contains emergency equipment, outbreak and civil defence supplies.</p> <p>There is sufficient water stored in a water tank. There is adequate food supply, and gas cooking (BBQ and gas hobs in the kitchen). Civil defence supplies are available in the event of an emergency (checked every six months). Emergency lighting is installed throughout the facility. A minimum of one</p>

		<p>person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>The call bell system has been upgraded. The staff carry cell phones, which are connected to the call bell system, these are on vibrate so there is no noise. There are screens around the facility if a call bell has not been answered within the specified time, this is displayed on the screen and the clinical nurse leaders are alerted. The GP interviewed commented this has made a difference to the stress levels of staff and residents throughout the facility. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells at hand in their rooms.</p> <p>All external doors are locked at dusk and opened at dawn. There is signage to inform relatives of the times the doors are locked.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The underfloor heating throughout the facility is centrally controlled. There are overhead heating/cooling air conditioning systems in the lounges. Heaters are available for residents if required. The maintenance person completes environmental temperature checks on a regular basis. The residents and relatives interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	PA Low	<p>The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the designated infection control coordinator with support and supervision from the clinical manager and support from the Arvida support office. Surveillance statistics are provided to the monthly RN meeting however it is not clear what committee acts as the IC committee. Minutes of meetings are available for staff. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Arvida infection control programme has been reviewed annually at support office. There have been no outbreaks since previous audit.</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</p>	FA	<p>A registered nurse is the designated infection control (IC & P) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation (link 3.1.1). The IC coordinator is supported by the clinical manager and there is external support from the Arvida Group support office and a microbiologist. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>

meet the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	The Wood uses the Arvida group infection control policies and procedures. The policies and procedures are appropriate for the size and complexity of the service and organisation. 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 (link 3.1.1).
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. The IC coordinator has completed online MOH training. All staff complete infection control education on the Altura system. Hand hygiene competencies have been completed and the last IC in-service was held March 2019. 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>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	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. This data is monitored and since March this year trends have been summarised and documented monthly by the clinical manager. Infection control surveillance is discussed at the RN meetings. 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.
Standard 2.1.1: Restraint	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit, there were three residents with restraints, and six residents using enablers.

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>Enabler use is voluntary, and a consent is documented where enablers have been requested. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff receive training around restraint minimisation and enablers and challenging behaviour.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>A registered nurse is the designated restraint coordinator. There are clear lines of accountability and responsibilities including consent and assessment processes. Assessment and approval process for restraint use included the restraint coordinator, RNs, resident/or representative and GP.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the three restraint files reviewed (bedrails), assessments and consents were completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are implemented. An assessment form/process is completed for all restraints which link to interventions on eCase. The three restraint files reviewed had a completed assessment and interventions within the care plan that reflected risk. Evaluations were not regularly documented (link 2.2.4.1). Monitoring was documented regularly in the worklog on eCase. The service has a restraint and enabler register that is updated monthly.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	PA Low	<p>There are documented processes around individual restraint evaluations and overall restraints at the service. The restraint policy states restraint evaluations are to include the areas identified in 2.2.4.1 (a) – (k). Care plans were evaluated six monthly which includes restraint. Assessment processes identify monitoring and evaluation requirements. However, restraint evaluations were not documented as</p>

		completed by the restraint coordinator. There is no current committee responsible for restraint use review and evaluation. Restraint use is not documented as discussed in key meetings.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The organisation gathers restraint usage across all sites and benchmarks restraint use. Restraint reports are provided to the clinical managers from support office at least annually. Restraint internal audits are completed as per schedule at The Wood and was last completed June 2019. Individual approved restraint is reviewed through the care plan evaluations (link 2.2.4.1). A monthly restraint/enabler register is monitored and updated monthly by the restraint coordinator. There is no formalised restraint committee at The Wood (link 2.2.4.1). Regular education has been provided to staff.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	There is a self-medication competency for assessment for residents wishing to administer their own medications. One respite resident did not have a drug chart or self-medication competency on place.	One respite resident did not have a drug chart or self-medication competency on place.	<p>Ensure all documentation and drug charts are in place on admission to the service.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	Each resident has an initial assessment, and an interRAI assessment which informs the long-term care plan developed which link triggers identified in the interRAI assessment, however	(i) Three long-term hospital residents did not have the interRAI assessment	(i)-(ii) Ensure all interRAI assessments and long-term care plans are completed

		these are not always completed within timeframes. The service monitors interRAI assessment timeframes monthly through their internal audit process. Corrective actions are established where required. All care plans have been reviewed at least six monthly and show progression towards meeting goals.	completed within 21 days of admission. (ii) Four hospital residents did not have a long-term care plan developed within timeframes.	within timeframes. 180 days
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	All residents' files reviewed had assessments completed on admission according to their needs and medical history. Assessments were reassessed when there was a change in condition, however, not all residents had all risk assessments completed as per policy.	Three of five hospital level and one of five rest home files reviewed did not have falls risk assessments completed as per policy.	Ensure policy is followed, and all risk assessments are completed accordingly. 90 days
<p>Criterion 3.1.1</p> <p>The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.</p>	PA Low	The governing body has implemented guidelines around IC in their Infection Prevention and Control programme policy which describes roles and accountability at a village level. However, there is no clearly appointed IC committee or quality committee as described in the policy. Infection statistics are reported at the RN meeting. Infection surveillance and	There is no committee appointed at The Wood that has overall responsibility for infection control as described in the organisations	Ensure there are clear lines of accountability and committee overall responsible for IP&C at The Wood.

		oversight is maintained at an organisational level. The national quality manager completes monthly reports on infection statistics across all the villages and includes infections documented from The Wood.	policy.	90 days
<p>Criterion 2.2.4.1</p> <p>Each episode of restraint is evaluated in collaboration with the consumer and shall consider:</p> <p>(a) Future options to avoid the use of restraint;</p> <p>(b) Whether the consumer's service delivery plan (or crisis plan) was followed;</p> <p>(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);</p> <p>(d) Whether the desired outcome was achieved;</p> <p>(e) Whether the restraint was the least restrictive option to achieve the desired outcome;</p> <p>(f) The duration of the restraint episode and whether this was for the least amount of time required;</p> <p>(g) The impact the restraint had on the consumer;</p> <p>(h) Whether appropriate advocacy/support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;</p> <p>(j) Whether the service's policies and procedures were followed;</p> <p>(k) Any suggested changes or additions required to the restraint education for service providers.</p>	PA Low	There are documented processes around individual restraint evaluations and overall restraints at the service. The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). However, restraint evaluations were not documented as completed by the restraint coordinator across the three restraint files reviewed. There is no current committee responsible for restraint use review and evaluation.	However, restraint evaluations were not documented as completed as per policy. There is no current committee responsible for restraint use review and evaluation at The Wood and there is no documented evidence that restraint is being reviewed in meetings.	<p>Complete restraint evaluations as per policy. Ensure restraint use is reported and reviewed at meetings.</p> <p>90 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.	CI	<p>The Wood has a philosophy that includes positive ageing and as part of this, has developed a number of initiatives to increase the engagement of residents with the community they live in; to a level that exceeds the required standard.</p> <p>The service identified that linking with the community, when in care can be quite difficult. Various intergenerational programmes have developed, between teenagers and the residents, which was featured in the local newspaper. Contact with animals (part of normal life) has been encouraged, with both dogs visiting, and even a horse – which made the national news bulletin. There is increased engagement with the local tourism centre, and international students visit, creating cultural connections. This supports the Arvida Wellness pillar of Engaging Well.</p>	<p>The Wood was involved in a National pilot programme for Tea and Tech, an intergenerational interactive exchange of technical advice for those who maybe are less savvy in such aspects. This involved planning alongside a staff member from Age Concern, trialling with two different schools to work out students that would bond well with their residents. Initially this was fortnightly and as the residents became more skilled it expanded out to once per month. They now have three older persons from the community participating each month also. There was significant community interest in the outcome of the first pilot of Tea and Tech, involving a reporter coming to interview and photograph residents in action.</p> <p>The service has also been creating art on rock which they have distributed in parks within the region, placing their email on the back, encouraging people to email their photos when the rocks have been found. This has been very successful.</p> <p>The service also runs a monthly community wellbeing meeting for</p>

			<p>all residents (family, friends and staff are also all welcome). From that came Wild Wood Games Night and other events. The Wild Wood games night is held weekly, totally resident led and organised.</p> <p>Over the past year they have had a university student working in the DT department completing a degree in Sport and Recreation. The student completed a project 'developing activities in the community encouraging residents to get outside of the facility'. The main purpose and drive of this was to encourage integration with the wider community and diminish social isolation. Within this project the student and DTs completed a range of outings from shopping, to visiting cafés, local attractions, parks and the beach. Survey results from residents in March 2019 identified an improvement around activities and choices since previous audit.</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The DTs identified that residents admitted to the CCW were not always able or wanted to attend the group activities on offer around the facility. A project was implemented to engage them more.</p>	<p>A comfort trolley was set up with a range of sensory equipment which can be wheeled into resident's rooms. The trolley contains nail care equipment, massage oils, aromatherapy oils and diffusers, a stereo with a range of musical CDs, a light ball for light therapy, perfumes, and make- up. There is a range of equipment and therapies available to settle residents such as weighted blankets, and mechanical pets for residents to have. Doll therapy is available to residents.</p> <p>One resident interviewed preferred not to engage in facility activities and was self-conscious of their condition. The resident commented on the trolley that was accessible to staff and enjoyed the aromatherapy oils they had tried as they were relaxing. Staff interviewed were knowledgeable of the contents and often used the trolley in the evenings and over the weekend for residents with unsettled behaviours.</p> <p>The DTs and residents have "with these hands" photographs on display, which allowed residents to reminisce on their life achievements, and have presented this to the public for a display for The Wood. This has resulted in an increase in communications between residents, staff and families and has</p>

			created a talking point and place to reflect. This is in-keeping with the living well model of care.
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End of the report.