

Waikanae Country Lodge Limited - Waikanae Country Lodge

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Waikanae Country Lodge Limited
Premises audited:	Waikanae Country Lodge
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 June 2021 End date: 11 June 2021
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:	54

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Waikanae Lodge is owned and operated by the Arvida Group. The service provides rest home and hospital level of care for up to 79 residents in the care centre and 20 residents at rest home level in the serviced apartments. On the day of the audit there were 54 residents.

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

The service is operated by a village manager (registered nurse) who has been in the role since April 2021. She is supported by a clinical manager (RN) who has been in the position since November 2020 and two clinical leaders (RNs). The village manager and clinical manager are supported by a national quality manager, registered nurses and wellness partners (caregivers).

The previous shortfalls around internal audits and neurological observations have been addressed.

This surveillance audit identified areas for improvement around meetings, education and aspects of care planning.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies are implemented to support residents' rights, communication and complaints management. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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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 and relatives are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported, and managed. Falls prevention strategies are in place that include the analysis of falls incidents. An education and training programme is documented 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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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. An integrated activity programme is implemented for residents. Residents and a relative reported satisfaction with the activities programme. Medication policies and procedures are implemented. Staff 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 building has a current building warrant of fitness. Preventative and reactive maintenance occurs. The facility is spacious and provides easy access to all communal areas. Outdoor areas are well maintained and provide seating and shade.

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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Waikanae Lodge has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were three residents using restraint and two residents using enablers. Assessments and consents were fully completed. The clinical manager is the designated restraint coordinator. The restraint committee reviews restraints and enabler use.

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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A registered nurse is the infection control coordinator, who is supported by the clinical manager. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Surveillance data is reviewed and discussed with the infection control committee. Covid-19 was well prepared for. Policies, procedures and the pandemic plan have been reviewed to include Covid-19. Wellness declarations are completed by all visitors and contractors entering the facility.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	4	0	0	0
Criteria	0	37	0	4	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 1.1.13: 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 interviewed (ten caregivers, two registered nurses (RN), two enrolled nurses (EN), one wellness leader, one kitchen manager (health and safety rep) and one maintenance person) are aware of the complaints process and to whom they should direct complaints. An electronic complaints register is maintained. One complaint has been received since the last audit. The complaint reviewed had been managed appropriately with acknowledgement, investigations and responses recorded. Residents and the relative interviewed advised that they are aware of the complaints procedure and how to access forms. The residents and relative interviewed state the staff and management are approachable, and they feel comfortable discussing concerns with them.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Six residents (four rest home and two hospital) 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. Ten incident/accidents reviewed for May and June 2021 had documented evidence of family notification where required. One relative (hospital level) confirmed relatives are informed of changes following GP reviews and are invited to care plan reviews or updated if changes have been made. In the resident files reviewed there was</p>

<p>provide an environment conducive to effective communication.</p>		<p>evidence in the progress notes around relative's notification of changes, meetings with relatives and the GP, and any changes in resident status. The village manager and the clinical manager (interviewed) have an open-door policy.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Waikanae Country Lodge is owned and operated by the Arvida Group. The service provides care for up to 79 residents. There are 59 dual purpose beds in the care centre and 20 serviced apartments certified for rest home level care. On the day of the audit, there were 54 residents in the care centre: 28 residents at rest home level care (including one resident on long term support – chronic health contract (LTS-CHC) and one resident on respite), and 26 residents at hospital level care (including three residents on respite and one resident on ACC). All other residents were admitted under the age-related residential care (ARRC) contract.</p> <p>The village manager (RN) has been in her role since April 2021 and has a background in aged care management, quality roles and mental health services. She is supported by a clinical manager (RN), who has been in her role since November 2020, and has a background in aged care nursing. The village manager and clinical manager are supported by the Wellness and Care team. The national quality manager visit two weekly and peer support is provided by a neighbouring village manager. The village manager reports to the national general manager of sales. A monthly report is provided to the national quality manager.</p> <p>Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Waikanae Country Lodge has a quality plan for 2021–2022. The plan includes rolling out the living well model of care, this is discussed in the weekly clinical meetings, and the combined quality meeting.</p> <p>The village manager has completed in excess of eight hours of professional development in the past 12 months including a six-month course on leadership in action. The clinical manager is booked on to the next leadership training through Arvida, is booked to attend an external leadership study day.</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</p>	<p>PA Low</p>	<p>There is a quality plan for Waikanae Country Lodge that links to the overall Arvida goals/strategies. Interviews with staff confirmed that there is discussion about quality data various meetings. A clinical lead has taken responsibility for the quality portfolio with support from the village manager. They 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.</p> <p>Arvida Group policies are reviewed at least every two years across the group. The service policies and processes meet relevant standards and link 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. Corrective actions are in place for areas of non-compliance identified. This is an improvement from the previous audit. There are a number of corrective actions currently in place for areas of non-compliance identified including</p>

<p>improvement principles.</p>		<p>(but not limited to); staff education, equipment, falls, and medication errors. Staff interviewed could describe the quality programme corrective action process.</p> <p>Due to the changes in management late 2020, facility meetings and resident meetings have not always been documented as held according to the schedule, however meeting minutes available evidence discussion around quality data. This was confirmed during staff interviews.</p> <p>Annual resident satisfaction surveys have been conducted. The net promoter score between the 2020 and 2021 survey showed a decrease in satisfaction from 53 in 2020 to 43 in 2021, however, satisfaction with care staff, clinical care, activities, and housekeeping scores have remained the same. Increased satisfaction was identified around providing residents with choice, and staff getting to know residents.</p> <p>There is a combined quality/ health and safety and infection control team. The health and safety representative (interviewed) has oversight of hazards reported and reviews staff incidents and enters data onto the electronic system. The health and safety representative has completed level one training and is booked to complete level two. Hazard identification forms are completed by staff on paper, then reviewed by the health and safety representative and entered onto the electronic system. The hazard register is available in hard copy and electronically and was last reviewed in November 2020. Health and safety education for staff is provided through the Altura education platform. The health and safety representative and village manager attend health and safety national meetings and discuss key points at the combined quality/ health and safety and infection control meeting.</p> <p>Falls prevention strategies are implemented including identifying residents at higher risk of falling and the identification of interventions on a case-by-case basis to minimise future falls. Falls are analysed monthly by the clinical lead with the quality portfolio, who collates, analyses and trends all resident falls and provides staff with graphs of data. Falls data and corrective actions are discussed at facility meetings. Fall prevention strategies include the use of low beds, sensor lights, night lights, and regular monitoring.</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</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. A monthly analysis is completed by the clinical lead (quality). There is a discussion of incidents/accidents at meetings held in May and staff interviewed confirmed discussion of incidents at staff handovers. An RN conducts clinical follow-up of residents. Ten electronic incident/accidents were reviewed and demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observations were recorded and completed according to policy for any unwitnessed falls with potential for a head injury. An ongoing corrective action plan remains open to monitor post falls follow up and completion of neurological observations.</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 one notification made for one non-facility acquired unstageable pressure injury in 2020.</p>

<p>their family/whānau of choice in an open manner.</p>		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience, and veracity. Six staff files were reviewed, including one clinical manager, one clinical lead (RN), one wellness leader, one wellness partner, one cook and one housekeeper. There is evidence that reference checks were completed before employment was offered. There is a current corrective action plan in place around completion of appraisals. A catch-up plan was implemented, due to a high staff turnover in 2020, many appraisals are not yet due. Currently there are only six staff with outstanding appraisals, and these are booked. The village manager has met with staff in small groups and individually to discuss their issues, concerns and stresses they face. There has been an all-staff meeting held which included setting expectations and provided an open invite to discuss concerns.</p> <p>A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An induction coordinator has been appointed to oversee completion of the orientation programme. The service has introduced an orientation programme for all new staff that provides them with relevant information for safe work practice. Staff described the orientation programme. Appropriate staff are trained in first aid, however not all first aid certificates on file were current. First aid training was booked on the day of the audit.</p> <p>The in-service education programme for 2020 was not evidenced to have been completed according to the plan, therefore not all compulsory education sessions have been completed. A correction action plan has been developed including the clinical lead (quality) overseeing education staff complete on the Altura online platform.</p> <p>From May 2021 education has been implemented in accordance to the wellness calendar as set out by the organisation. Self-directed learning sessions online through Altura are being completed as scheduled according to the theme of the wellness calendar month. This ensures all compulsory education sessions will be completed. Competencies have been completed by staff for medications, infection control and handwashing, fire safety (last fire drill held in May 2020), chemical training is booked to be held within the next month.</p> <p>The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the district health board (DHB). The other clinical lead (learning coordinator) is an assessor for Careerforce. 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. Currently there are 11 caregivers who have completed New Zealand Qualification Authority (NZQA) qualifications through Careerforce (four caregivers have completed level 4, five have completed level 3 and two with level 2).</p> <p>The clinical manager and one enrolled nurse are trained in interRAI with another two RNs booked onto the next available course.</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>	<p>FA</p>	<p>The village manager (who is a registered nurse) and clinical manager work 40 hours per week from Monday to Friday. In addition to the village manager and clinical manager there are two clinical leaders. (One quality and one education). The village manager, clinical manager and the clinical leads provide advice/ on call after hours. On the day of the audit there were 54 residents: 28 rest home level residents including one resident on LTS-CHC contract and one resident on respite. There were 26 hospital residents including three recently admitted respite residents and one recently admitted resident on an ACC contract). The facility is staffed as one with the RNs allocating staff to areas according to resident acuity.</p> <p>There is at least one RN on duty each shift supported by either another RN or and EN. One RN is on duty overnight.</p> <p>During the audit, the GP, nurses, caregivers, residents and the relative felt at times the facility was short staffed.</p> <p>There are eight caregivers rostered on the morning shift; 4x 7am to 3.15pm, 3x 7am to 2pm and 1x 8am to 3pm.</p> <p>There are seven caregivers rostered on the afternoon shift; 4x 3pm to 11pm, 1x 3pm to 9pm and 1x 4.30pm to 10pm.</p> <p>There are three caregivers rostered on the nightshift; 2x 11pm to 7am and 1x 11pm to 7.15am.</p> <p>The serviced apartments are supported by the combined roster with staff being allocated to work across the different communities and depending on acuity and resident numbers.</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>FA</p>	<p>Clinical staff who administer medications (RNs, enrolled nurses and medication competent caregivers) have been assessed for competency on an annual basis. Annual education around safe medication administration has been provided through the online Altura platform. All staff who administer medications have a current competency in place. Registered nurses complete syringe driver training. Medications are stored securely in line with current guidelines. Delivery of robotic packs are checked against the medication charts and recorded in the electronic medication system once completed by the RNs. All eye drops, and ointments sighted were dated on opening.</p> <p>Medication room, and medication fridge temperatures are recorded daily and were all within expected ranges. The service has implemented an electronic medicine management system. Twelve electronic medication charts (the sample was increased to review two respite residents' paper-based medication charts). All had photo identification and allergies documented. Permanent resident medication charts reviewed had been reviewed by the GP at least three-monthly. 'As required' medication had indications for use documented and efficacy was documented in the medication system. There was one resident in the rest home who self-administers an inhaler. There was a self-medicating competency in place which had been reviewed three monthly and medication was stored securely.</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>There is a centrally located commercial kitchen in the facility. All food and baking is prepared on site by the kitchen team. There is a current food control plan in place expiring on 14 June 2022. There is an organisational menu in place which has been reviewed by a dietitian. Freezer, chiller, and fridge temperatures are recorded daily and were all within expected ranges. Temperatures are checked on receiving cold foods, and at end cooking. Temperatures of the bain-marie is checked and recorded. Cleaning schedules are maintained.</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, and resident requests are accommodated. Special diets were noted on the kitchen noticeboard. The kitchen manager interviewed was knowledgeable around resident preferences, likes and dislikes. Alternatives and dietary supplements are available. The main meal is at lunchtime. Feedback is received, and the menu can be altered to swap meals for resident's dislikes.</p> <p>The dining area is situated adjacent to the kitchen. Meals are served directly from the kitchen servery to the residents in the dining room. The dining room is spacious and provides adequate room for residents with mobility aids. Tray service is provided to residents who choose to dine in their rooms. Residents and the relative interviewed were overall stated satisfaction with the food service.</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>PA Low</p>	<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 relatives 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 documented in the medication system for residents on PRN pain control medication. Interventions for short-term needs are added to the long-term care plan and resolved once the acute issue has resolved, or interventions remain on the long-term care plan if the issue continues.</p> <p>Overall, the care plans documented were resident focused; however, not all care plans included interventions to support current needs of the resident. The respite resident had appropriate assessments and an electronic care plan.</p> <p>The RNs interviewed described having access to specialists including the hospice, district nurses, continence service and the stoma nurse, and Arvida nurse specialists. 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; however, these were not always fully completed. There is dietitian involvement where required.</p> <p>There were 15 wounds on the day of the audit including (but not limited to); skin tears, abrasions, surgical wounds and one venous ulcer. There were three stage 2 and three stage 1 pressure injuries. All skin tears were</p>

		<p>categorised. All wounds had individual electronic assessments, wound management plans and evaluations in place. Photos were taken at regular intervals to evidence progression or deterioration of the wound. The district nurses have had involvement to apply compression bandaging for the resident with the venous ulcer</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Monitoring occurs for weight, blood pressure, behaviour, wounds, blood sugar levels, pain, neurological observations, restraint, food and fluid charts. Neurological observations were fully completed electronically for the unwitnessed fall incident reports reviewed, there is an ongoing corrective action plan documented around this. The previous shortfall around neurological observations has been addressed, however, monitoring forms for restraint monitoring and position changes were not consistently completed as instructed in care plans.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is managed by a part time qualified diversional therapist and a wellness leader (interviewed) who works full time and has been in the role for 18 months. The service has a plan around implementing the living well model into the activities programme and integrating activities between residents in the serviced apartments and in the care centre.</p> <p>The wellness team organise virtual speakers including the stroke foundation, age concern and the blind foundation They invite all residents, including those in the serviced apartments, to attend. The sessions have been well attended and assisted with the integration of resident from the care centre and serviced apartments. The wellness team spread their time across the rest home, hospital, and residents in the serviced apartments) from Monday to Friday, although all activities are open for all residents to attend if they choose.</p> <p>Residents receive a copy of the weekly programme which has set daily activities and additional activities such as entertainers, outings, yoga, movies, and visits out to the community.</p> <p>A resident lifestyle assessment is completed soon after admission. Lifestyle plans are included in resident electronic files. The activity team are involved in the six-monthly review of resident's care plan with the RN, however, not all care plans were fully completed (link 1.3.6.1). The service receives feedback and suggestions through resident's verbal feedback and surveys. There was no documented evidence of resident meetings for 2020 or 2021 to date (link 1.2.3.6).</p> <p>There are two main areas for activities: the main lounge and the gallery. Resources are readily available in the lounge adjacent to the activity office. One-on-one activities such as individual walks, chats and hand massage occur for residents who are unable to participate in activities or choose not to be involved in group activities.</p> <p>The activity team provides individual and group activities. These include (but are not limited to), nail cares, crosswords and quizzes, entertainment, church services, group games, arts and crafts and outings. The wellness team are looking at re-introducing visits from schools and preschools in the area, which has been postponed due to</p>

		<p>Covid-19. The service has two vans for outings into the community which accommodates residents in wheelchairs. Outings are to places of interest to the residents and often include afternoon tea. The younger residents can choose to be involved in any of the facility activities and had regular one on one activities.</p> <p>Both wellness leaders first - aid certificates have recently expired. First aid training was arranged on the day of the audit (link 1.2.7.5).</p> <p>The residents and relative interviewed were happy with the variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>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, however, this is not always completed within timeframes (link 1.3.3.3). Evaluations are documented on the electronic system which evidences progression towards meeting goals. The relative interviewed confirmed they are invited to attend the six-monthly MDT review (case conference) and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes and long-term care plans updated (link 1.3.6.1). Changes to the electronic long-term care plan identify name and date to reflect the update. Residents and the relative interviewed confirmed involvement in the care planning and evaluation process.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 30 November 2021. The maintenance person (interviewed) 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. Hot water temperatures in resident areas are monitored and maintained below 45 degrees Celsius.</p> <p>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. All communal areas are easily accessible and provide space for residents to move around freely with mobility aids. The outdoor areas are well maintained with seating and shade provided. The caregivers and RNs interviewed stated they were looking forward to the new equipment purchased to arrive.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Infections are entered into the infection register on the electronic data base. Monthly infection data is collected for all infections based on signs, symptoms and definition of infection. This data is monitored and analysed for trends monthly by the clinical lead (quality) and the clinical manager. Infection control</p>

<p>in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>surveillance is discussed at the facility meetings. There have been no outbreaks since the previous audit.</p> <p>Covid 19 was well prepared for. The facility followed organisational directives. Policies and procedures have been updated to include Covid19. Adequate supplies of personal protective equipment were sighted during the audit. All visitors and contractors complete a wellness declaration and contact tracing in line with current guidelines.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.2. The service has documented systems in place to ensure the use of restraint is actively minimised. The facility are currently three hospital level residents using bedrails as a restraint. Assessments completed and interventions in the care plan identify risks associated with the use of bedrails. Consents were appropriately signed, however monitoring charts were not consistently completed as instructed in the care plan (link 1.3.6.1) and there was no evidence of education around restraint or enabler use (Link 1.2.7.5) Enabler use is voluntary. Two residents were using bedrails as enablers. Assessments and consents were in place. Restraint has been discussed as part of the RN/ clinical meetings.</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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	A plan of scheduled meetings has been documented for 2021. Meeting minutes evidenced meetings were held regularly in 2020 until September. However, not all meetings were able to be evidenced as taking place as scheduled. Since the village manager has been employed there have been two quality (including infection control and health and safety) meetings, a clinical meeting and two staff meetings. All were held in May 2021. The implementation of weekly clinical review meetings ensures all departments in the facility are continually abreast of changes in the facility. Two clinical leads interviewed report this has improved communication between the management team and the nursing team, key points are discussed during handovers with care staff.	i). Quality, infection control, and staff meetings were unable to be evidenced as occurring according to schedule from October 2020 to May 2021. ii). Meeting minutes could not be located	i). Ensure facility meetings are held as scheduled. ii). Ensure resident meetings are reinstated and held regularly 90 days

			for resident meetings for 2020, and no resident meetings have been held to date in 2021.	
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There is a 2021 education plan set out by Arvida around the Living well model of care, which Waikanae Lodge are now following. There are ‘themes of the month’ for example medicine management May. Education sessions are to be completed by appropriate staff around medication management and staff who administer medications complete medication competencies. The clinical lead (quality) oversees the education sessions staff complete using the Altura education system. Education completed by caregivers has been recorded on an electronic spreadsheet, however not all compulsory education sessions were evidenced as being completed by appropriate staff. Appropriate staff are supported to complete first aid training; however, it was identified that not all certificates were current. Training was booked on the day.</p>	<p>i). Education sessions were not evidenced as being completed as scheduled around restraint, cultural safety, falls minimisation, continence, and sexuality and intimacy.</p> <p>ii). There was no evidence of permanent staff (RNs/ ENs wellness team, or caregivers) with current first aid certificates.</p>	<p>i). Ensure education sessions are held as scheduled.</p> <p>ii). Ensure a staff member with a current first aid certificate is rostered on for each duty.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision</p>	PA Low	<p>InterRAI assessments were completed six-monthly either by the clinical manager or the enrolled nurse with sign off by the clinical manager. Information in the interRAI assessments were linked to the information in the long-term care plans. However,</p>	<p>i). One rest home resident on the LTS-CHC contract</p>	<p>Ensure all care plans are developed</p>

<p>(assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>not all care plans were developed within expected timeframes.</p>	<p>did not have the long-term care plan reviewed for a period of nine months.</p> <p>ii). The long-term care plan was not developed in three weeks for one hospital resident.</p>	<p>and reviewed within expected timeframes.</p> <p>180 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>A suite of monitoring forms are available on the electronic system for nurses to utilise on the electronic system. Monitoring forms in use in the resident files reviewed, were not consistently completed.</p> <p>Overall, the resident care plans were individualised and reflected resident's needs. Progress notes were well documented by staff which reflected the residents needs and interventions implemented, however, not all assessments and care plans were fully completed.</p>	<p>i). Monitoring forms were not consistently completed for two hospital level residents on restraint and one hospital resident with current pressure injuries.</p> <p>ii). Care plan interventions were not documented in the care plan for one hospital resident with current pressure injuries.</p>	<p>i). Ensure monitoring forms are consistently completed as instructed in resident care plans.</p> <p>ii). Ensure call care interventions are included in the care plans.</p> <p>iii). Ensure assessments are fully completed.</p> <p>iv). Ensure all leisure care plans are fully</p>

			<p>iii). The mini nutritional assessment completed had no interventions documented for two hospital residents.</p> <p>iv). There were no interventions in the leisure care plan for one hospital resident</p>	<p>completed.</p> <p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.