St Allisa Rest Home (2010) Limited

CURRENT STATUS: 07-Feb-13

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.

GENERAL OVERVIEW

St Allisa Lifecare, situated in Riccarton, Christchurch, provides hospital, rest home, dementia and young person disability (YPD) services for up to 112 residents. There have been major renovations since the last certification audit, and refurbishment of rooms will continue as rooms are vacated. On the days of the audit there were 105 residents with six hospital residents in the upstairs Selwyn (previously Bowen) wing. All wings have had name changes to reflect the rivers of Canterbury, and the New Zealand theme is a focus the manager will continue as refurbishments continue. The refurbishments are of a high standard with outdoor areas that are easily accessed, including in the dementia wing.

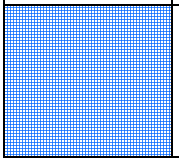
The owner manager was present for the audit and has been involved as manager at the facility on and off for the past 25 years. She has been part of the owner syndicate group since 2010. The quality co-ordinator with an infection control background has been in her current role for two years, and along with the owner manager, they form the management team. Professional development is supported by the facility and all staff are trained to the required levels to provide the level of support that meets the needs of the resident group. Staffing levels have increased to reflect the increased number of residents following the recent renovations.

There are five areas requiring improvements relating to: advance directives to meet legislative requirements; analysing quality data; updating care plans; individualising activity plans, including goals; and management of medication.

AUDIT SUMMARY AS AT 07-FEB-13

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded

Indicator	Description	Definition
	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
	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

Consumer Rights	Day of Audit 07-Feb-13	Assessment
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.		**Some standards applicable to this service partially attained and of low risk**

Organisational Management	Day of Audit 07-Feb-13	Assessment
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**

Continuum of Service Delivery	Day of Audit 07-Feb-13	Assessment
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**

Safe and Appropriate Environment	Day of Audit 07-Feb-13	Assessment
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**

Restraint Minimisation and Safe Practice	Day of Audit 07-Feb-13	Assessment
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**

Infection Prevention and Control	Day of Audit 07-Feb-13	Assessment
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**

AUDIT RESULTS AS AT 07-FEB-13

Consumer Rights

There is evidence the facility provides services which respect the rights of residents, allow for informed choice, and support cultural, spiritual and individual rights and beliefs. Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process, is on display at the front entrance hallway, is provided in the admission package, and brochures available throughout the facility in communal areas.

Residents and family interviewed verify they are given adequate time for explanation and discussions to take place, and are able to access the owner manager if any issue arises; they comment she is always readily available. Admissions are not rushed and the owner manager spends time to ensure the resident is placed in the most appropriate wing in the facility.

The Service has an easily accessed and responsive complaints process.

There is one area of required improvement to ensure advance directives meet legislative requirements.

Organisational Management

Organisational structures and process are monitored and reported against. The owner manager is responsible for the overall service delivery. She works at the facility and is involved in everyday service provision. The owner manager is a registered nurse with over 25 years' experience in the aged care sector. Key components of service are explicitly linked to the quality and business planning process to ensure services are provided to meet residents' and the needs of the community.

Actual and potential risks are identified for all aspects of service delivery. Risks sighted in the business plan, the risk plan and in the hazard plan identify the differing levels of actions that need to be taken to manage the risk to keep staff, residents and visitors safe.

All incidents, accidents and untoward events are recorded, evaluated and reported at staff and management level meetings. Documentation, including residents' clinical files, and resident and family/whānau interviews, confirms there is good sharing of information in an open and honest manner.

Safe staffing levels and skill mixes are maintained by St Allisa Lifecare. All shifts are covered by a registered nurse with a current first aid certificate. The dementia unit has dedicated, appropriately educated staff rostered at all times. Human resources management processes implemented meet legislative and good practice requirements. There is a system in place to identify, plan and facilitate on-going staff education.

Residents' records are legible, dated and signed with the author's designation. Records are secure, and those reviewed are integrated, and current. Obsolete documents are securely stored and managed to meet legislative requirements.

There is one particular strength identified related to the risk management system with processes and evaluation which is rated beyond the normally expected level of attainment.

There is one required improvement related to the recording of falls data.

Continuum of Service Delivery

The needs assessment and service co-ordination (NASC) service have information to inform prospective residents of the service, including all levels of care provided by the facility.

Registered nurses (RNs) develop the residents' care plans which guide care staff in service provision. Care plans are detailed, individualised, and reviewed at least six monthly, and interventions are included to reflect the resident's desired outcomes. Observation of care provision and progress notes written by care staff and RNs verify that staff are able to follow care plans. There is documented evidence in residents' files of referral to other service providers and resident and family choices are being respected.

A physiotherapist and a general practitioner (GP) were interviewed during the audit. The physiotherapist assesses all new residents and those who have been transferred from hospital. She states staff carry out her recommendations within safe timeframes. This is

consistent with comments from the GP, who also states RNs follow instruction and notify him in a timely manner. He is contacted after hours as required and the facility accesses emergency services appropriately.

Care staff were observed providing services in a dignified and respectful manner, knocking on doors, and addressing residents in a quiet and respectful manner. Group activities are planned monthly and provided in the main lounge by an activities person and in the dementia wing by a qualified diversional therapist. Activities are appropriate and varied and include one-to-one activities for those residents when this is more suitable. 'Happy hour' is provided twice weekly, and the auditors observed, jovial social interactions between residents.

There are two areas requiring improvements relating to care plans when progress is less than expected, and individualised activity plans, including goals being identified.

Policies and procedures are in place for all stages of medication management. Storage of medicines meets legislation and guidelines. A robotics system is implemented, and records sighted meet standards and guidelines. Care staff or RNs, assessed as competent to do so, follow a GP prescription record to administer medications. Two medication administrations are observed on the days of the audit. Areas requiring improvement relate to medication records and security of the medication trolley.

A dietitian has reviewed the current menu and recommendations have been implemented. A dietary profile is completed for each resident on admission and any special dietary needs are provided, and listed in the kitchen. Likes and dislikes and special requirements are met, including fortified foods and extra food available overnight. Auditing of food transportation, storage and preparation is occurring. Residents and family members interviewed state the residents are happy with the food service provided and that this meets their needs. Weights are monitored monthly and there are currently no residents with decreasing weight.

Safe and Appropriate Environment

The facility is on two levels. The current lift accommodates emergency service transportation chairs and residents sighted using the lift during audit managed without difficulty. The facility has had a refurbishment of the down stairs area and some of the upstairs. On-going refurbishment is identified on the business plan. On the days of audit all areas are safe, appropriate and accessible to the residents. Currently, all bedrooms are single occupancy. There are two bedrooms that can be used by couples; on the days of audit one room is empty and the other has one occupant. All bedrooms have full ensuites, this includes the dementia wing. Dining, lounge and recreational areas meet residents' needs, as confirmed by residents and family/whānau interviewed.

Emergency training and security responses are well documented and understood by staff, including management of waste and hazardous substances. Six monthly fire evacuations are maintained. There are adequate food, water and emergency supplies, should they be required.

The building has a current certificate of practical completion and they are waiting for the building warrant of fitness from the council, which takes up to 15 working days. The service has a fire evacuation plan which has been approved by a registered fire provider. The plan

has been trialled and there were no corrective actions required. There is an appropriate system in place for reactive maintenance and a documented long term maintenance plan.

The facility is kept at an even temperature via electric heating and opening of doors and windows. Room temperatures are monitored to ensure the temperature remains comfortable at all times. There are well kept outdoor areas that have seating and sheltered areas for the use of residents. The dementia unit has a large secure outdoor area that is enjoyed by residents.

The service has an effective cleaning and laundry service which implements all policies, procedures and tasks as identified in documentation sighted.

The facility is smoke free with a nominated area outdoors for residents who smoke.

Restraint Minimisation and Safe Practice

The restraint register sighted identifies the service minimises the use of restraint. Eight residents have restraint in use for safety reasons only at the time of audit. Policy and procedures are implemented to ensure the process used for determining restraint approval meets all requirements. The only approved restraints are bedside rails and chair lap belts. Alternative techniques are used prior to restraint approval being given as appropriate. Assessment and monitoring processes meet all Health and Disability Services Standards requirements.

Restraint and enabler use is identified on residents' care plans. Residents who have restraint are reviewed monthly by the restraint co-ordinator and six monthly by the multidisciplinary team. The resident and family/whanau are involved in the approval and on-going use of restraint. Enablers are clearly described as being voluntary and are used to keep residents safe while encouraging independence.

An annual quality review of restraint is presented to the owner manager; this identifies audit results, corrective actions and their outcome, and the number and type of restraints in use.

Staff interviews and documentation sighted confirm staff education covers all aspects of restraint and enabler use. Staff interviewed demonstrate knowledge and understanding of the process.

Infection Prevention and Control

The infection control (IC) RN has an extensive background in IC practices and brings this experience to her role. The IC programme includes policies and procedures to guide staff in the prevention and minimisation of infections. The IC programme and the 'Bug Control' guidelines contain all the requirements of the Standards. The IC RN is able to gain advice from external experts as required, or the facility's visiting GPs.

All staff receive IC education on induction and orientation and at least annually thereafter; and quizzes ensure the content remains relevant.

The facility IC RN collects monthly surveillance data for each of the three areas in the facility and provides a report to the quality meeting.