

# St Allisa Rest Home (2010) Limited

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## 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 The DAA Group 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:

<b>Legal entity:</b>	St Allisa Rest Home (2010) Limited
<b>Premises audited:</b>	St Allisa Lifecare
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 29 October 2014      End date: 30 October 2014
<b>Proposed changes to current services (if any):</b>	Nil
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	103

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

St Allisa Rest Home Limited provides care for up to 110 residents in a suburb on the western side of Christchurch city. Hospital and rest home care is provided along with support for 13 young people with physical disabilities and a 20 bed dementia service.

The environment is clean and well-maintained, although some post 2011 earthquake repairs have yet to be completed. Services provided at St Allisa's are meeting the assessed needs and preferred outcomes for the residents and high levels of satisfaction about these are consistently expressed.

This surveillance audit reviewed the issues identified as requiring improvement at the certification audit and all have been addressed to a satisfactory level. However, four new areas of low risk that require improvement have been identified during the surveillance. These relate to the complaints process, the need for a menu review and the need for a review of the restraint process. The care plan evaluation and review processes still require attention, although the issues are different from the lack of short term care plans noted at the last audit.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Management and staff communicate effectively with residents through a resident's meeting. Residents and family members interviewed confirm they are kept well informed and that staff support them to understand their care and treatment. They state that registered nurses and the manager are all approachable and will update them on progress whenever they visit the facility or ring if there is a change in the resident's condition. All individual files have advance directive forms that have been completed appropriately. The required improvement identified at the previous certification audit has been fully addressed. The complaints process is easily accessible to residents and families; however improvement is required to ensure all aspects of Right 10 of the Health and Disability Services Consumers' Rights are implemented.

## 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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St Allisa Lifecare has a 2014 business plan which describes the goals and values of the organisation. The owner manager is a registered nurse who has worked in the industry for many years and maintains a current practicing certificate. St Allisa Lifecare has an established quality and risk management system with processes developed over a number of years. There is a current risk management plan covering key areas of the service. A suite of policies and procedures are in place, and are regularly reviewed on a two yearly cycle. A range of meetings include a quality and risk management meeting and a health and safety meeting. These two key meetings have set agendas to address key quality, operational and clinical activities, with other regular meetings

contributing to the content of these meetings. Staff confirm feedback and outcomes from meetings is consistently provided, either directly, through a staff communication board or meeting minutes.

All incidents, accidents and untoward events are recorded, evaluated and reported at staff and management level meetings. Key aspects of service delivery, such as infection control, incidents and accidents, hazards, audit results and changes in policy and practice are linked to the quality system through the meeting structure. Internal audits are undertaken and service areas according to an annual audit schedule. New risks and hazards are also raised, discussed, monitored and mitigated. Data is collected, collated and analysed to enable areas for organisational improvement to be identified and addressed through a corrective action process. Champions promote good practice in particular clinical areas. A previous required improvement related to the analysis of falls data and follow-up action from analysis of infection control data. Review of current processes confirms that data now includes “frequent fallers” and this addresses the previous requirement.

There is a well-structured in service staff education programme which is adapted to meet the needs of staff and the facility. Care giving staff education is based around the Aged Care Education (ACE) programme, including the dementia programme for staff working in the Waimarie unit. There are on-site assessors for the diversional therapy and ACE programme. Other staff groups also complete components of the ACE programme e.g. diversional therapists and foodservice staff. Ongoing training opportunities are detailed in a 2014 staff education programme. Experienced external facilitators are accessed to ensure good nursing practices are upheld. The programme is amended during the year to reflect changes in requirements within the facility. Staffing levels and skill mix support safe practice and service delivery within the facility.

## 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 a commitment to staff training within this service and registered nurses provide ongoing planning, evaluation and supervision of services delivered to residents. Full assessments are made of the needs and abilities of residents and the results are used to develop individualised care plans. An activities programme is available in the hospital, rest home and dementia service areas. The programme in the dementia service is being especially well delivered and documented. All residents have an activities plan with relevant goals that are being evaluated, which has addressed an issue raised at certification. Long term care plans are being evaluated and reviewed every six months; however some of the identified changes are not being transferred into the intervention section of the plan. Although short term care plans are now being developed and resolved, there is a lack of documented reviews of the interventions to demonstrate the progress being made. These are areas requiring improvement, although these differ from those raised at the certification audit, which have been addressed. Medicine management is safe and meets the requirements that are outlined in legislation and guidelines. Records demonstrate that medicines are being administered according to the GP prescriptions and that there is oversight from the pharmacy. Medicine related issues raised at the certification audit have been addressed. Meals are prepared according to a four week rotating menu that has been reviewed by a dietitian. Implementation of the dietitian's recommendations is an area requiring improvement. Individual preferences and nutritional needs are being met. Foods are being stored and prepared in a safe manner in a clean environment.

## 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 facility holds a current Building Warrant of Fitness valid until March 2015. There have been no changes to the current building since the issue of the certificate. Staff undertake regular fire evacuation updates.

## 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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Consistent review of residents since the previous audit has reduced the overall use of restraint in the facility through the introduction of alternative strategies wherever possible. Four residents are using enablers of their choice. Staff interviewed confirm understanding of the difference between a restraint and an enabler, as well as documentation and monitoring requirements for residents using restraint. Records confirm implementation of organisational restraint processes. Improvement is required to ensure the quality review of restraint is comprehensive in accordance with the standard.

## 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 comprehensive infection surveillance programme is being implemented. Each infection that is confirmed according to the documented definition and criteria is recorded. Monthly, three monthly and annual records are being analysed, reviewed, graphed and reported. Results guide decisions about infection control education and actions.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	14	0	4	0	0	0
<b>Criteria</b>	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: 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>A required improvement identified at the previous certification audit has been fully addressed. All individual files have Advance Directive forms that have been completed appropriately, except for two where the doctor has signed that the person does not have the required level of competence. The advance directive forms now in use have the resident's signature as well as that of the general practitioner. The advance directive requests the resident to indicate the level at which they want clinical investigations/treatment in the event of serious illness. Additional notes have been added when appropriate and a doctor assesses cognition for making such decisions. All advance directives are dated.</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>	PA Low	<p>St Allisa Lifecare has a complaints form available in the entry area and accessible to residents and families from admission. Families also communicate with the management via email, with evidence of communication on file. A feedback process is described in a flow chart document and a letter of acknowledgement to the complainant. However, for two complaints made by family members in the last 12 months, this has not been utilised in accordance with organisational policy or timeframes and requires improvement. Follow-up responses are included and</p>

		<p>documentation reviewed includes a letter of apology to the complainant. The complaints process would benefit from clear delegation of authority to address complaints in a timely manner in the manager's absence.</p> <p>There is an up-to-date complaints register which records all complaints received. The manager states that she makes every effort to address any concerns before they escalate. Examples described indicate this is an effective strategy. Five of five staff interviewed understand the complaints process and are able to describe how they address any resident family concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The service has a documented policy on open disclosure. Incident reports and follow-up actions include open disclosure. One recent example of a resident fall includes timely family contact. Multidisciplinary meetings are also used as opportunities to communicate effectively with the resident and their chosen family member(s). Resident meetings are held regularly, with minutes of these meetings sighted for 2014. This includes open communication of matters which impact on residents such as renovations, meals and changes to the organisation's structure. Residents and management report this to be a robust, open and effective mechanism for communication in the organisation. Minutes provide an insight into resident satisfaction, relationships with staff and the opportunity to discuss any matters of concern.</p> <p>Residents interviewed are clear that they are kept well-informed about what is happening for them. They say staff are always talking to them and will re-explain things if necessary, such as after the doctor visits. The family members interviewed state that the registered nurses (RN's) and the manager are all approachable and will update them on progress whenever they visit and will ring if they think it is important (such as if their relative becomes sick). A communication log is not used for all relatives' visits, however key issues such as invites to the six monthly multi-disciplinary team meetings, following a significant fall and advising of a pending re-assessment are adequately documented.</p> <p>The organisation has made provision for access to interpreters and/or external services, where required.</p>
<p>Standard 1.2.1: Governance</p>	FA	<p>St Allisa Lifecare has a 2014 business plan which links to other documents such as the risk management plan. This clearly articulates the goals and values of the</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>organisation. The values are made known with a framed values statement in the entrance.</p> <p>The owner manager has been in her role at St Allisa since 2010. She has previously been involved with St Allisa and worked in aged care for many years. She is a registered nurse with a current annual practising certificate. She is visible and accessible to residents and staff and has a hands-on approach to her management role as observed during the surveillance audit. Some consideration is being given to succession planning with leadership and management development occurring for senior staff. This is to be encouraged. The owner manager expresses pride in the service, the organisation's commitment to investing in staff development, including development of "champions" as well as a strong team culture.</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>St Allisa Lifecare has an established quality and risk management system and processes. There is a current risk management plan covering key areas of the service. This is reviewed annually, however, would benefit from a greater focus on management of items of greater risk or those risks which are changing. The quality meeting structure would be enhanced by inclusion of specific organisational risks as a regular agenda item.</p> <p>A suite of policies and procedures is in place, and reviewed on a two yearly cycle to ensure any changes in legislation or practice are addressed.</p> <p>A quality coordinator is employed one day per week – her role includes collation of data, and support for staff who are "champions" for key areas of the service as well as management of documentation. She has a particular focus on following through to ensure improvement occurs when deficits are identified from surveys, audits and complaints. She has a particular role in the management of infection prevention and control in the facility and is an experienced infection prevention and control practitioner who provides training throughout New Zealand.</p> <p>The owner/manager and quality coordinator confirm a range of meetings are held to address operational and quality activities. Meetings are generally scheduled three monthly, with a primary focus on the quality meeting, and health and safety. The quality meeting has set agenda items including infection control and hospital-acquired infection rates, results of audits e.g. nursing, activities and service area reports. Reports from other staff meetings also feed into the two meetings. Staff interviewed confirm feedback and outcomes from meetings is consistently given,</p>

		<p>either directly, through a staff communication board or meeting minutes.</p> <p>A range of organisational data is collected and collated. Key aspects of service delivery, such as infection control, incidents and accidents, hazards, audit results and changes in policy and practice are linked to quality through the meeting structure. New risks and hazards are also raised, discussed, monitored and mitigated. Champions for particular clinical areas or requirements such as continence, restraint, nutrition, falls, infection control and wound care, support best practice in these key areas. Resident surveys are undertaken, the last being in October 2013. Information is fed back appropriately to families and residents through newsletters and resident meetings. Internal audits are undertaken in service areas according to an annual schedule (sighted). Results are collated by the quality coordinator, analysed and reported through the meetings. Where changes are required, these are followed through and their effectiveness validated, as evidenced through the corrective action log and meeting minutes. Other examples include a robust nursing documentation audit which includes the care plans, clinical content, and progress notes. Any identified deficiencies are monitored through the meeting, responsibilities are assigned and the item closed out at the next meeting once completed. There is an opportunity to better align the content of the nursing documentation audit with the changes brought about with the introduction of InterRAI.</p> <p>Restraint data is verbally reported by the restraint coordinator at the quality meeting. This remains raw data, however, and there is no evidence of analysis of trends in relation to restraint minimisation. (See corrective action 2.2.5.1).</p> <p>A previous required improvement related to the analysis of falls data and follow-up corrective action of infection control data. Review of current processes confirms that data now includes "frequent fallers" within the total falls data numbers. The health and safety and quality meetings include infection control and the corrective action log demonstrates follow-up is completed and closed out.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>A robust accident and incident reporting process is in place using the incident reports. Five care and household staff interviewed described reporting processes. The owner manager signs off all incident reports and these are subsequently collated and analysed each month to determine trends. The quality coordinator reviews reports as part of gathering data and, where necessary, a corrective action process is implemented. There are a number of examples of this occurring for a range of events. Corrective actions are not closed until a satisfactory outcome is achieved or the problem is adequately addressed. Staff interviewed report their use of incident reports on a regular basis and that they have confidence in the process. If they are in</p>

		<p>doubt about the need to report an adverse event, they will discuss it with either the manager or registered nursing staff.</p> <p>The service is aware of its statutory and regulatory obligations to report or notify adverse events and management can cite a number of examples. There are currently no examples under review by statutory or regulatory bodies.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Examples of the human resource management processes, confirm that these are conducted in accordance with good employment practice. New employees undergo a recruitment process which involves an application process, two referee checks, police vetting, validation of professional qualifications where appropriate and an interview process. Appointment is confirmed in an employment contract and scope identified in the position description. This is confirmed from review of the documentation for a recent registered nurse appointment. Position descriptions are in place for each staff member. All staff interviewed report they have a current performance appraisal.</p> <p>Orientation is tailored to each staff group and the service area. Staff interview confirms a thorough orientation process is offered and completed. If necessary, additional support/orientation is arranged for the new employee. In most cases, an experienced buddy is assigned to support the new employee in practical tasks and a structured generic programme introduces the employee to the organisation – examples include health and safety, infection control, fire evacuation, incident reporting as well as clinical tasks.</p> <p>There is a system to manage professional qualifications and registrations such as renewal of annual practising certificates for nursing staff - all registered and enrolled nursing staff have current annual practising certificates. The lists include renewal of First Aid certificates and registration for contracted staff such as general practitioners, physiotherapists and electricians. First Aid certificates are maintained for registered nursing staff and diversional therapists who take residents on outings away from the facility. Ongoing validation of professional qualifications is an administrative task. It is noted that the lists identify staff through a highlighting process, when annual practising certificates and other renewals are due. Some of these appear out of date from the list, which on further checking are confirmed as current. It is suggested that the system is reviewed to become a "bring up" and checking system ahead of the due dates.</p> <p>Caregiving staff education is based around the Aged Care Education (ACE)</p>

		<p>programme, including the dementia programme. All staff working in the dementia unit are required to complete the dementia unit standards. The names of staff who have completed the full National Certificate are displayed on a name board at the entrance to the facility. Education is supported by on-site assessors for both diversional therapy and the ACE programme. Records and interview with staff who work across service areas of hospitals, rest home and the dementia unit confirms that this occurs. Other staff groups also complete components of the ACE programme e.g. diversional therapists and foodservice staff. The cleaning staff have received direct education from the cleaning chemical provider, with two cleaners interviewed reporting recent completion of this.</p> <p>There is a well-structured in-service staff education programme which is adapted to meet the needs of staff and the facility. Ongoing education is detailed in the staff education programme for 2014. The programme is amended during the year to reflect changes in requirements within the facility. Examples completed this year include the “essence of palliative care” presented by Nurse Maude Hospice staff, infection control focused on hand hygiene, consumer rights, pain and symptom management presented by a well-known facilitator, and use of particular medication. Sessions are often repeated to enable a broad range of staff to attend. This is achieving higher attendance rates than would otherwise be possible. Records demonstrate between a third and a half of staff attend one or other of the sessions provided. Staff interviewed report active encouragement of attendance at in-service education sessions. Registered nurses also report attending external courses to suit their interests and needs. In most cases, the facility pays the cost of additional education. This is notable for one registered nurse undertaking leadership training who has been well supported in professional development. Registered nurses and caregivers interviewed (six staff) report a culture of learning and a variety of internal and external educational opportunities are available to them. The owner manager states she is proud to be able to offer these opportunities to the staff and credits their teamwork and sound knowledge base to be attributable to the ready availability of staff education.</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>There is a weekly roster prepared by the owner manager according to the organisation's defined staffing levels and skill mix policy. Rosters reviewed confirm that shifts are filled internally wherever possible. Registered nurses interviewed (two) state that the organisation seldom accesses casual staff from a bureau. If this does occur, casual staff are not allocated to the dementia unit unless they have worked there previously. No gaps are identified in the previous two weeks rosters sighted.</p>

		<p>Staff rotate through the wings every four to six months. At interview, care staff report that the workload is manageable and they support each other by sharing the workload across wings where necessary. They also report management listen to and act upon any concerns about workload.</p> <p>Registered nurses are allocated with two staff on morning shift plus a short shift, one registered nurse plus a short shift on afternoons, and one registered nurse on night shift. The registered nurse and enrolled nurse are rostered during weekends to cover all areas of the two storey facility. They are supported by appropriate numbers of care staff according to location and acuity. In the hospital wing there is one caregiver to five residents, with staff pairing up to work as a team in some circumstances. Staff are readily able to call for assistance with a sophisticated call system in place.</p> <p>The service employs trained diversional therapists under strong leadership by an experienced individual who works in the dementia unit. Two diversional therapists work in the hospital and rest home. Activities are provided Monday to Friday in the rest home and hospital and seven days a week in the dementia unit, where timing and provision of services is designed to meet the needs of residents with advancing dementia. This means activities are provided into the early evening.</p> <p>Six cleaning staff are employed to provide services daily across the whole facility. Weekends involve basic cleaning tasks throughout the facility. The kitchen rosters four staff to provide all facility meals each day.</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>All medicines are stored in the main medicine room or in one of the three lockable medicine trolleys, depending on the area. Casual checks on these found them to be locked each time. The pharmacy removes all unused stock. Controlled medicines are stored in a metal cabinet attached to the wall in the main medicine storage area and are being checked off by two people. Random checks show accuracy. All are being reviewed and signed by two people every week.</p> <p>In the twenty-one medicine records between the three different areas that are reviewed, all have medicine prescriptions that are signed by an authorised prescriber and any medicines that have been discontinued have a line through them and are signed and dated. Short course medicines have a specified timeframe. Allergies are recorded with orange alert stickers on those with any allergy identified. Orange alert stickers are also on medicine records of residents with duplicate/similar names.</p> <p>There is evidence of consistent three month review of medicines being signed by the</p>

		<p>GPs.</p> <p>The pharmacy provides printed administration sheets for the medicines. A medicine round is observed in two areas. Sample signatures of staff administering medicines are available and staff are signing off following their administration. Good practices are being maintained during the administration of medicines with only those labelled as crushable being crushed and the use of individual dispensing units for liquid medicines, for example.</p> <p>A medicine administration competency is in place. This involves a written and a practical component and the medicine administrators are responsible for getting another registered nurse to review their annual competency. There are gaps in the medicine administration competency register showing overdue reviews, which on investigation are found to be of people who no longer administer medicines, or who only work during the summer holiday, or who have left. It is suggested to the staff person responsible for the register that a more efficient system of recording is undertaken to ensure ongoing accuracy.</p> <p>Four residents are self-medicating according to organisational procedures. Each person has a self-medicating competency completed three monthly and the GP is confirming their cognitive ability at the three monthly reviews. One person did not have a locked drawer for the medicines; however this was remedied during the audit.</p> <p>Medicine records are being completed according to accepted practice. Reconciliation of incoming and altered medicines is being recorded on record sheets on clip boards which are signed off by a registered nurse. Medicines are being signed off following administration; there is evidence of pharmacy input into reviews of controlled medicines, the removal of medicines and of documentation. During the medicine round the registered nurses are observed to use the resident's name, answer questions and administer the medicine according to the prescribed method.</p> <p>From the evidence obtained during the audit, residents are receiving medicines in a safe manner and medicines are being prescribed, stored, disposed of, documented and administered according to accepted guidelines and legislation. The issues raised at the certification audit are no longer evident.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional</p>	<p>PA Low</p>	<p>The menu rotates every four weeks and although some changes are made between winter and summer there are not distinct summer and winter menus. Residents are given two choices of the protein content of the main meal each day. A dietitian</p>

<p>needs are met where this service is a component of service delivery.</p>		<p>reviewed the menu in May 2014 and has recommended that the menu be revised. This has also been raised as an area requiring improvement in this surveillance to ensure the food and fluids meet nutritional requirements. Results of a food survey sent to residents by the service provider are just being collated by the quality manager. The information is to be used to contribute towards the review of the menu.</p> <p>On admission to the facility, a dietary profile is completed by the registered nurse who provides a copy to the kitchen staff. These are added to a master list of the food preferences and requirements for all residents. Residents who have special dietary requirements such as puree and soft food, or allergies to foods such as mushrooms and shellfish are having these met. Lists of personal requirements for breakfast, hot drinks and any special dietary needs are consistently updated. One person requires percutaneous endoscopic gastrostomy (PEG) and this is being managed by the registered nurses. A list of individual meal preferences and needs is printed off each day and provided to the kitchen.</p> <p>Food storage, purchase, preparation and disposal are being managed in safe ways that are consistent with current legislation and guidelines. For example, use by dates are being documented, stock rotation is occurring, fridge and freezer temperatures are being monitored, hats are worn during food preparation and hand washing is promoted. Leftovers are disposed of after a meal, sandwich fillings are dated and stored for one day only and food waste is disposed through an insinkerator. The kitchen is kept clean and is part of the internal audit system, staff have undertaken safe food handling courses and the cook and her assistant attended a day of training on food safety and special diets including nutrition for people with diabetes.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Full nursing and medical assessments are in relevant sections of the resident's files. A diversional therapist also writes up a personal profile within the first week of admission. Specific assessments include a nutritional assessment on admission as well as assessments for falls risk, skin pressure, continence and pain. Personal files of four hospital residents, three dementia service, four rest home and three young residents with disabilities are reviewed. According to the progress notes, the three monthly activity plan reviews, the six monthly multi-disciplinary reviews, the medical notes and care plan reviews the residents are receiving services according to their needs and preferences. This is confirmed in conversation with fourteen residents from a cross-section of the different areas, although one person from the rest home expresses a strong preference not to be in care. Four relatives are also interviewed and are satisfied with the level of care being provided. All state that everyone is</p>

		<p>happy and that there is always someone to go to if there is a concern or things are not quite right.</p> <p>The requirements of the ARRC agreement have been reviewed and are being met.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>A separate monthly activity plan is developed in each of the dementia, the rest home and in the hospital services areas, although there are times when some of the groups may combine. The activities are varied and are applicable to the needs of the residents with options varying from newspaper reading, word games and quizzes to gardening, knitting, bowls, balloon hitting, outings and walks. Residents' safety is a key consideration. Qualified diversional therapists are assisted by staff who are currently undertaking diversional therapy training. One of the qualified diversional therapists pro-actively supports others in the team.</p> <p>All residents have activity related plans that include personalised goals and interventions. These address self-esteem, cultural needs and personal interests for example, that are consistent with information in the history/personal profile obtained on admission. Each goal is being consistently evaluated three monthly and again at the full six monthly reviews that are part of the wider multi-disciplinary team service delivery plan evaluations and reviews of progress. Areas around the planning and evaluation of lifestyle goals in individual activity plans, which were previously identified as requiring improvement, have been addressed.</p> <p>Although the activities plans and programmes are good in all areas, those in the dementia service are particularly notable as they are developed to help manage each person individually depending on the mood or general abilities of a particular person on a specific day. They include morning, afternoon and evening shift options with ideas on how to help people settle at night, or if they wake. There is a wide variety of activities that include care of the chickens and planting.</p> <p>In all areas time is set aside for people who require on-on-one time and this is especially evident for those who are under 65. Residents who are under 65 are pursuing their own personal interests that vary from paid employment to study, computers and personal hobbies. People have access to spiritual and cultural activities as they personally choose and these are documented in the individual service delivery files.</p> <p>The requirements of the ARRC agreement are being met.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Six monthly multi-disciplinary reports are being completed and are being used in a worthwhile manner to support the evaluation and review processes. The evaluation of personal goals in care plans is occurring every six months and includes the review of the services being provided. Likewise goals in the individualised activity plans are being reviewed three and six monthly. Progress towards meeting the desired outcome(s) is being documented and residents who are able confirm they are involved in this process. Relatives interviewed also say they have ongoing input with full reviews every six months.</p> <p>Where progress is different from expected, it is documented in the evaluation section of the care plans. However, there are examples of where changes in interventions are not being transferred across to this section of the care plan leaving contradictions between evaluation and intervention sections of the plans. Also, although short term care plans are now being used, as was a requirement identified at the last audit, there is a lack of evidence that there is ongoing review of these, and of the date they were resolved. Hence, further improvements are required to meet this standard.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>St Allisa Lifecare has a current Building Warrant of fitness issued by Firefighting Pacific valid to 1 March 2015. There have been no changes to the building or its use since the issue of this certificate. All owner responsibilities are current and up-to-date on the documents sighted. An Independent Qualified Person inspection report and sprinkler survey (dated July 2013) is sighted.</p> <p>Renovations are planned for early 2015, which will incorporate necessary earthquake repairs and carpet replacement. No date has been confirmed for this.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection prevention and control policies and procedures guide the surveillance of the incidence of infections, which is overseen by the quality manager, who is also the infection control officer, and by an infection control committee. Infection surveillance is undertaken according to the definition of an infection, a set of pre-determined criteria for inclusion in the surveillance and a list of infections, each of which is described.</p> <p>Records of the details of each infection are made and these identify the person(s), the area of the facility and details such as the mode(s) of treatment used. The quality manager subsequently develops sets of data on a monthly, three monthly and annual</p>

		<p>basis. The data is analysed, graphed and reported to quality meetings and to staff meetings and minutes are made available to staff. Examples of these are viewed and demonstrate the information is reviewed to guide implementation of the infection prevention and control programme. A focus on education about standard precautions and hand washing, including the use of 'glitter-bug' was the result of a review of data that showed there had been an increase in certain skin infections. There were no further incidences of this infection. Ensuring staff reported infections according to the definition of a urinary tract infection, for which additional education had been provided, and the promotion of hydration are examples of managing a spike in urinary tract infections. A fluid balance chart is also being reviewed to facilitate the recording of fluid intake and output of some residents as a result of surveillance results.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Consistent review of residents since the previous audit has reduced the use of restraints. In addition, residents are currently using enablers of their choice. Staff interviews confirm understanding of the difference between a restraint and an enabler, as well as the monitoring requirements for residents using restraint. Enablers do not require additional monitoring as identified in policy and the restraint register.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	PA Low	<p>Restraint monitoring occurs according to the organisation's policy. This regularly occurs through reporting to the quality and risk committee, as evidenced in meeting minutes for 2014 which refers to a verbal report. This needs to be formalised to evidence trending and analysis as part of a quality review process. While there is a commendable decrease in the use of restraint in the facility, there is no evidence of a comprehensive quality review process as required by the standard.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	An established complaints process is in place and a register maintained indicating two formal complaints have been received in the past twelve months.	Not all elements of the complaints process are implemented in accordance with organisational policy or Right 10 of the Code. e.g. evidence of the provision of advocacy information to the complainant, acknowledgement of receipt of the complaint within five days and dating and sign-off of each stage of the complaint process on the complaints form.	<p>The organisation implements its complaints management policy and flow chart in accordance with Right 10 of the Code of Health and Disability Services Consumers Rights.</p> <p>180 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines</p>	PA Low	There is a four week rotating menu, which has only minor modifications made between winter and summer. The cook informs the menu is followed unless circumstances prevent it such as a recent malfunction in the main	The dietitian has noted in her May 2014 review that the recommendations made in the previous review have not been addressed and has requested a full review of the current menu to ensure	That food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines.

<p>appropriate to the consumer group.</p>		<p>freezer. Residents mostly say they are satisfied with the food, however use the word institutional, saveloys and repetitive in conversation about it. A dietitian reviewed the menu in May 2014 and states in her report that that the recommendations made two years prior were not acted upon. The report includes a corrective action that a full menu review is undertaken. The service provider has commenced this process by distributing a food satisfaction survey, the results of which are currently being analysed. The managers state they will use this information to assist with the menu review. Meantime, the need for the menu to be reviewed to the level of satisfaction of the dietitian is identified as an area that requires improvement.</p>	<p>the nutritional needs of the residents are being met according to recommended nutritional guidelines.</p>	<p>180 days</p>
<p>Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Low</p>	<p>Evaluation and review processes are being completed for long term plans every six months. Changes are being noted in the evaluation section of the care plan, however the intervention section is not always being amended accordingly and this requires improvement. There are examples of the intervention/action section contradicting the evaluation section.</p> <p>Short term care plans are in place and note the date the issue was identified, some actions/interventions required and a stamp of resolution sits beside the nurse's signature. There are some examples in which a change in</p>	<p>Relevant changes are being identified and documented in the evaluation section of care plans, however the intervention section is not always being amended accordingly. Also, short term care plans are stating short term issues have resolved, however not all of these are dated and the ongoing review and evaluation processes undertaken in the interim are not always evident.</p>	<p>Changes are made to the intervention/action section of service delivery plans when indicated during evaluation and review process; short term care plans show evidence of ongoing review of the identified problem until resolution and the date of resolution is noted.</p> <p>180 days</p>

		antibiotic for example is noted, otherwise there is a lack of evidence that there was ongoing review of the identified issue and at least six examples of the resolution date not being included are sighted. Although the presence of a short term care plan addresses a previously identified area that required improvement, the use and implementation of them now requires improvement.		
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p>	PA Low	A verbal report on restraint use is provided by the restraint co-ordinator at the three monthly quality and risk management meetings as evidenced in the meeting minutes for 2014. This demonstrates a downward trend in restraint use over time.	<p>While provision of the report provides some monitoring opportunities, it does not constitute a comprehensive review of restraint practice as outlined in a) – h) of the standard.</p>	<p>Ensure that the service conducts and records a comprehensive and detailed review of all restraint practice in the facility.</p> <p>180 days</p>

<p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>				
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.