

St Allisa Rest Home (2010) Limited - St Allisa Lifecare

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

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

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

The specifics of this audit included:

Legal entity:	St Allisa Rest Home (2010) Limited
Premises audited:	St Allisa Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 13 March 2017 End date: 14 March 2017
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:	95

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

St Allisa is part of the Arvida group. St Allisa Rest Home provides care for up to 109 rest home, hospital (including medical), physical disability and dementia level care residents. On the day of audit there were 94 residents. The service has eight hospital rooms of the facility currently undergoing refurbishment which are closed to residents and staff.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The facility manager is appropriately qualified and experienced. Feedback from residents and relatives is positive.

Seven of the nine shortfalls identified at the previous audit have been addressed. These were around advance directives, incident reporting, training, registered nurse sign off of care plans, timeframes for completion of documentation, progress notes entries, aspects of medication documentation and hot water temperatures. Improvements continue to be required around care plan interventions and medication management.

The service has received a continuous improvement rating for the activity programme.

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.
--	--	--

Residents and family are well informed including of changes in resident's health. The care home manager and clinical manager have an open-door policy. Complaints processes are implemented and complaints and concerns are managed and documented and learning's from complaints shared with all staff.

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.
---	--	--

St Allisa has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. The service is benchmarked against other Arvida facilities. Incidents are documented and there is immediate follow up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff having input into rostering.

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.
--	--	---

The registered nurses are responsible for each stage of service provision. A registered nurse assesses the resident and develops the care plan documenting support, needs, outcomes and goals with the resident and/or family/whanau input. Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three monthly.

There are two activities programmes running with four trained diversional therapists covering seven days of the week. The programmes include community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents and families report satisfaction with the activities programme.

Resident 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 dietary requirements/modified needs were being met. There are nutritious snacks available 24 hours.

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.
--	--	--

The service has a current building warrant of fitness. The facility has redecorated all but eight resident's rooms during an eighteen-month renovation project. The eight hospital rooms currently under refurbishment were not occupied and were not accessible to staff or residents. Internal communal areas have been redecorated and a new commercial kitchen has been installed since the previous audit. There were no changes to fire plan or emergency planning required as all renovations were cosmetic and were not structural.

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.
---	--	--

There is a restraint policy that includes comprehensive restraint procedures including restraint minimisation. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were two residents on restraint and two with enablers.

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.

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Arvida group facilities. Staff receive ongoing training in infection control.

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	1	15	0	2	0	0	0
Criteria	1	39	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families. The Arvida Group Advance Directive policy (including resuscitation) was developed and implemented in June 2016 and provides clear guidance to staff. A 'Not for Resuscitation' medical form is completed by the GP for residents who are not competent to make a decision and have no prior advance directive in place. A review of six resident files evidenced that the resuscitation status for each resident was clearly documented. The audit finding from the previous certification audit has been addressed.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected,</p>	FA	<p>The complaints procedure is provided to resident/relatives at entry and prominently displayed at the reception area and around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. The complaints register records five complaints were received since the last audit.</p> <p>Documentation including follow-up letters and resolution reviewed demonstrated that complaints are well managed. Discussion with residents and relatives confirmed they were provided with information on complaints</p>

and upheld.		and complaints forms.
<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>Four relatives (one hospital, one rest home and two dementia) interviewed stated they are informed of changes in health status and incidents/accidents. Accident/incident forms have a section to indicate if family/whānau have been informed (or not) of an accident/incident. Incident forms for February 2016 reviewed identified that family were notified. Incident and accident forms are audited as part of the internal audit process.</p> <p>Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about services and procedures. The service has policies and procedures available for access to interpreter services for residents (and their family). There are currently no residents who have needed to access this service. There is one resident for whom English is not the resident's first language. Staff described the use of picture boards to assist the resident to communicate with staff as the resident, when tired, will lapse back into speaking her first language.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>St Allisa Rest Home provides care for up to 109 rest home, hospital (including medical), physical disability and dementia level care residents. On the day of audit, there were 94 residents which included 49 rest home, 26 hospital and 19 residents in the dementia unit. There were 10 younger persons (seven rest home and three hospital). There were four rest home respite residents. The service has eight hospital rooms of the facility currently undergoing refurbishment which are closed to residents and staff.</p> <p>The service has a business plan which is reviewed annually. The business plan identifies the purpose, values and scope of the business. The service has quality goals which are reviewed at the health and safety/quality management meetings.</p> <p>The service is managed by an experienced facility manager (registered nurse) and is supported by a clinical manager who has been in the role for two years.</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</p>	FA	<p>There is a quality plan that includes quality goals and risk management plans for St Allisa. There is evidence that the quality system continues to be implemented at the service. Interviews with staff confirmed that quality data is discussed at monthly staff meetings to which all staff are invited. Additionally, all quality data is comprehensively covered in the monthly combined health and safety/ quality meeting, as part of the weekly management meeting. The quality manager advised that she is responsible for providing oversight of the quality programme. However, the facility manager advised that the role of quality manager at a facility level was being disestablished and that the overall management of clinical quality forms part of the role of the Clinical Manager. The Arvida quality and risk management programme is designed to monitor contractual and standards compliance. The Arvida Group policies</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>have been implemented and include interRAI requirements.</p> <p>Resident/relative meetings are held. Restraint and enabler use is reported within the health and safety/quality meetings and at staff meetings.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</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>The service documents and analyses all incidents/accidents. Individual incident reports are completed for each incident/accident with immediate action noted. This finding from the previous audit has been addressed. The data is linked to the Arvida group benchmarking programme and this is used for comparative purposes. Incident reports are assessed for a means to prevent recurrence before being signed off. All incident forms for February 2016 reviewed documented immediate follow up by a registered nurse including completion of neurological observations for all unwitnessed falls or falls with a possible head injury.</p> <p>Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.</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</p>	<p>FA</p>	<p>There are human resources management policies in place which include that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed (the clinical manager, one diversional therapist, two caregivers, one cook and one registered nurse) and all evidenced that reference checks are completed before employment is offered.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2016 has been completed and the 2017 programme is being implemented. Education on skin care and pressure injury prevention and management was last delivered in October 2016 and cultural safety education in January 2017, evidencing that this previous audit</p>

<p>requirements of legislation.</p>		<p>finding has been addressed.</p> <p>There are 13 healthcare assistants who work routinely in the dementia unit and 11 have completed the dementia standards. The remaining two caregivers have not been employed for one year. All staff in the dementia unit have completed “walking in another’s shoes” dementia education provided by CDHB. There are two diversional therapists who work in the dementia unit. The clinical manager and registered nurses are able to attend external training including sessions provided by the local DHB. The Arvida group hosts two conferences per year for managers and clinical managers to promote the updating of skills and knowledge. Seven of ten RN’s are interRAI trained. Annual staff appraisals were evident in four of six staff files reviewed; the other two staff were new to the service.</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>Policies include staff rationale and skill mix. Sufficient staff are rostered on duty to manage the care requirements of the residents. The clinical manager works 40 hours per week Monday-Friday. The facility manager who works full-time Monday-Friday is also a registered nurse. There is one registered nurse rostered in the rest home five days per week on the morning shift. In the hospital, there is one registered nurse on morning shift and 1.5 registered nurses on the afternoon shift seven days per week. There is one registered nurse on night shift. There are three care staff on duty in the dementia unit in the morning and afternoon and one on night duty.</p> <p>The registered nurse from the hospital (which is on the ground floor adjacent to the dementia unit) oversees and provides input for the dementia unit. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. There is evidence in the adjust of rosters to manage increases and decreases in occupancy or increased resident need.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. There were two residents assessed as competent to self-administer medication and competency assessments had been completed and reviewed three-monthly. Individually prescribed resident medication charts reviewed are complete; regular medications signed for and ‘indications for use’ recorded for all ‘as required’ medication. The service has addressed this previous finding.</p> <p>All medications were securely stored. Expired medication and unlabelled medication were found on the days of audit. There is evidence of weekly controlled drug checks completed by registered nurses. Standing orders at time of audit were reviewed and currently valid. The service has addressed this previous finding.</p> <p>Registered nurses and senior caregivers administer medications. Staff responsible for medication administration have completed annual medication competencies. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors are recorded and reported to the supplying pharmacy. Medication errors are reported as part of the health and safety/quality and (staff) meeting. Medication profiles reviewed were</p>

		legible and up to date. All medication charts have been reviewed three-monthly by the GP. The medication fridge has temperatures recorded daily and these are within acceptable ranges.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>St Allisa has a new commercial kitchen where all food is prepared and served. The service employs one cook and one relieving cook. Both have completed food safety certificates and the head cook has completed NZQA Units 167 and 168. The cook interviewed explained the procurement of the food and management of the kitchen, for which she is responsible.</p> <p>The service has introduced two separate sittings for meals. One sitting for residents' requiring assistance and one sitting for more independent residents.</p> <p>In the dementia unit, meals are served in the unit dining room. On the day of the audit, meals were observed to be hot, served from bain-marie's and are well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge, food, freezer and dishwasher temperatures were monitored and documented daily and were within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. Special diets were noted on the kitchen noticeboard.</p> <p>Nursing staff complete a daily resident preference (two choices offered for main dinner served at midday). The menu is a four-weekly seasonal menu. Residents and families interviewed, expressed satisfaction with the food service and can provide feedback through a food survey and at resident and relative meetings. Resident weights are monitored monthly or more frequently if required. Dietary supplements are available. There is adequate emergency food stock for all residents for five days.</p> <p>Snacks are available to residents 24/7. Sandwiches, puddings, biscuits and fruit were observed stored in the dementia unit fridge and cupboards.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>The previous audit identified that identified needs were not always addressed in care plans sampled. This audit identified that long-term care plans reviewed did not all fully describe the support required to meet the resident's goals and needs. This previous finding has not been fully addressed.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to): accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file. Short-term care plans document appropriate interventions to manage short term changes in health and are signed off by the registered nurse upon completion.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds. Wound assessments are comprehensive and were evidenced to be fully completed and contained the classification, size and location of the wound. This previous audit finding has been addressed.</p> <p>There were four pressure injuries on the day of audit. Incident forms were evidenced completed for each wound. There was a range of equipment readily available to minimise pressure injury. Chronic wounds have been linked to the long-term care plans (also link 1.3.5.2). Monitoring charts were completed and evidenced two-hourly position changes had been completed. This is an improvement implemented from the previous audit. There was evidence of wound nurse specialist involvement in the management of pressure injuries.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified</p> <p>Resident weights are recorded monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident's nutritional status and preferences.</p> <p>Monitoring occurs for weight, vital signs, blood glucose, pain, challenging behaviour, wounds restraint and continence. The previous audit finding around monitoring of pain has been addressed. Registered nurses review the monitoring charts and report identified concerns to the GP or DHB nurse specialist.</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</p>	<p>CI</p>	<p>The service provides two activities programmes with four trained diversional therapists (DTs) delivering the programme over seven days of the week. One DT oversees and coordinates the activity programme for the dementia care level residents and one DT oversees and coordinates the activity programme for the rest home and hospital level residents. There are two part-time DTs supporting these programmes.</p> <p>There are two 'Spark of Life Practitioners' and all staff in the dementia unit have completed 'walking in another's shoes'. The DT interviewed stated they have been part of the community pilot dance group (with older person's mental health) for residents with dementia. Entertainers attend the home regularly and there are regular outings and drives for all residents. Residents are supported to attend religious services of their preference. Special events and festivities are celebrated; families are invited to attend. There are alternative activities (one on ones, books, word games, walks in the gardens) provided. An activity assessment and plan is completed on admission</p>

service.		in consultation with the resident/family (as appropriate) and reviewed six-monthly. Residents and families have the opportunity to feedback on the activity programme via individual feedback, meetings and surveys. Resident and relatives interviewed expressed satisfaction with the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans reviewed were evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed at least six-monthly or earlier for any health changes. The written evaluation documents the resident's progress against identified goals. The GP reviews the residents at least three-monthly or earlier if required. Six-monthly MDT meetings were evident where residents and relatives attend. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	St Allisa displays a current building warrant of fitness which expires on 1 March 2018. A new commercial kitchen has been installed since the previous audit. Resident rooms and communal areas have been refurbished over the last eighteen months. At time of audit, there are eight resident rooms under refurbishment. The refurbishment has included painting and redecoration of all rooms, including replacing furniture and curtains. The dementia unit has also been redecorated and all resident room doors have been painted a different colour to resemble the resident's front door of their previous home. This has been implemented to assist with resident orientation. There is a lift between both floors which has room for a hospital stretcher. The rest home is located on the first floor and the hospital and dementia unit are on the ground floor. Hot water temperatures in resident areas had been maintained within the acceptable limit of 45 degrees. The service has addressed this previous finding.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the various facility meetings and results posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical manager and facility manager.

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were two residents with restraint and two residents with an enabler. Enabler use is voluntary. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Recently updated policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of health and safety/quality meetings. The clinical manager is the designated restraint coordinator.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. All 12 medication prescribing charts and medication signing charts reviewed evidenced that medications were prescribed and administered as per policy and procedure. However, expired medication was found in medication trolleys and not all prescribed medication had a pharmacy label to identify the medication and dose.	(i) Expired medications were found in one medication trolley; and (ii) One Midazolam spray currently in use in the hospital medication trolley was noted to have no pharmacy label to identify name of medication, dose, expiry date and name of resident prescribed for. This was addressed on the day.	<p>(i) Ensure there is a process to check expiry dates of medication; (ii) Ensure all medications have a pharmacy label to identify name of medication, dose, expiry date and name of resident prescribed for.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans</p>	PA Low	All residents had interventions documented in care plans by a registered nurse. Five of the six files reviewed documented comprehensive interventions for all	One of six resident files did not document interventions for all identified needs around	Ensure care plans document the required support

describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.		identified needs.	restraint.	and/or interventions required to meet the resident's needs. 60 days
---	--	-------------------	------------	--

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The facility provides an activity programme that is varied and developed to meet the individual needs of residents. Each resident has an activity assessment completed on admission and an activity plan is developed and reviewed six-monthly or when there are changes to resident's interests, needs or abilities. The facility reviewed the activity programme and dementia environment in 2016. The service has seen an increase in satisfaction of the activity programme reported via the resident/relative survey in 2016. This evidences a continuous improvement.</p>	<p>In 2016, a review of the activity programme was implemented. In the dementia unit, each resident has a different coloured room door. The resident is able to choose the colour where able or on consultation with family, the colour of the residents own front door when living at home is used. There are picture story boards depicting each resident's treasured memories. One DT interviewed stated this change in environment has resulted in improved orientation for residents. Residents were involved in making the memory/picture boards. All staff who work in the dementia unit have completed “walking in another's shoes” dementia care workshops. The facility is participating in the DHB pilot of afternoon dance classes for residents with dementia.</p> <p>Activities are held in several locations within the facility. There is a variety of activities that include resident choice as a focus. There is 'doll therapy' (EPOA consent) available, there are animals (rabbit, two chickens, cat, bird and a virtual breathing cat) belonging to the dementia residents and they have a men's shed</p>

			<p>(tool box) available for those residents who wish to participate in garden projects.</p> <p>Volunteers involved in the activity programme include family, primary school children and community speakers. Entertainers attend the home regularly and there are regular outings and drives for all residents. Residents are supported to attend religious services of their preference. Special events and festivities are celebrated; families are invited to attend. There are alternative activities (one on ones, outings for coffee or lunch, books, word games, walks in the gardens) provided.</p> <p>An activity assessment and plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed six-monthly. Residents and families have the opportunity to feedback on the activity programme via individual feedback, meetings and surveys. Residents and relatives interviewed stated they were very happy with the activities, stating 'it was a really vibrant warm home and staff were very kind and caring, we are able to come and go and be actively involved with our loved one's everyday life'.</p> <p>The programme is catered to meet the needs of the individual (including younger people), so each resident has a specific activity plan which included trip to movies, out for coffee, like to buy a lotto ticket, family take resident out each week, go ten pin bowling.</p> <p>The hospital YPD resident interviewed preferred one-on-one activities and there was evidence that they were happening in the progress notes.</p> <p>There was a 28% increase in satisfaction recorded with the activities programme from the January to June 2016 (72%) to July to December 2016 (100%) resident/relative satisfaction survey results.</p>
--	--	--	--

End of the report.