

Adriel Rest Home Limited - Adriel Resthome

Introduction

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

The audit has been conducted by 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:

Legal entity: Adriel Rest Home Limited

Premises audited: Adriel Resthome

Services audited: Dementia care

Dates of audit: Start date: 18 April 2017 End date: 19 April 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: 37

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

Adriel Rest home provides dementia rest home care for up to 42 residents in two facilities. The service is operated by a single owner and managed by the facility manager and the owner/registered nurse. Families spoke positively about the care provided.

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

This audit has resulted in a continuous improvement related to activities and identified areas requiring improvement relating to medications, kitchen service and shared rooms.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent. Written consents are obtained from the residents' families/whānau, enduring power of attorney, or appointed guardians. Family members interviewed stated that open communication is promoted and the facility provides families with the information that they require to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination. There was one resident who identified as Māori residing at the service at the time of audit. There are no known barriers to Māori residents accessing the service.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs. Residents are encouraged and supported to maintain community and family links and family members reported that they were always made to feel welcome when visiting.

A complaints register is maintained with complaints resolved promptly and effectively. Staff were observed to demonstrate good knowledge and practice related to respecting residents' rights in their day to day interactions. Families and residents interviewed, expressed high satisfaction with the care delivered.

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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the owner is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents. Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family. Residents are admitted to the service by the qualified and trained registered nurse who completes an initial assessment and then develops a long-term care plan specific to the resident's identified needs using the interRAI assessment system. When there are changes to the resident's needs a short-term plan is developed and integrated into a long-term plan, as needed. The files reviewed demonstrated that the service meets the contractual time frames for all care plans and are reflective of individual resident's need. Residents are reviewed by the general practitioner (GP) on admission and assessed thereafter on a three-monthly basis, or in

some cases, more regularly depending on their needs. If required, referrals to the DHB and community health providers are requested in a timely manner.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. Diversional therapists provide planned activities meeting the identified needs of residents as individuals, and use a variety of techniques to engage with residents, including the Spark of Life philosophy and activities. Families reported that they are happy with the level and variety of the activities that are offered and that their relatives appear happy and engaged.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Both buildings have their own on-site kitchen which caters for their residents. Food is available 24 hours of the day and any identified resident dietary requirements are catered for. Resident likes and dislikes are recorded on the food plans located in both kitchens. The service has a six week menu which had been approved by a registered dietitian. Families interviewed reported satisfaction with the meals and upon observation; the meals were presented in an appetising manner.

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.		Some standards applicable to this service partially attained and of low risk.
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The facilities meet the needs of residents and are clean and well maintained. There is a current building warrant of fitness for each building. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

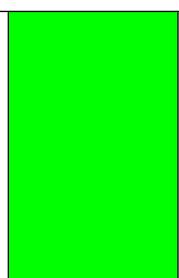
Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Family members reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Three restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint processes.

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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The service has an appropriate infection prevention and control management system. The infection control programme is implemented and monitored by the owner / registered nurse and aims to provide a reduced risk of infections to staff, residents and

visitors. Relevant education is provided for staff. There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where negative trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported and discussed at staff and quality meetings. The facility has access to the DHB clinical nurse specialist in infection prevention and control and follow up action is taken as and when required.

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	46	0	3	0	0	0
Criteria	1	96	0	3	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in visible locations at both buildings. On the day of audit, a Consumer Rights poster in Māori was missing but this was replaced. Policy relating to the Code is implemented and staff described how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction and this was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Clinical files and interviews confirmed that informed consent had been obtained appropriately using the organisation's standard consent form. Advance care planning and enduring power of attorney (EPoA) requirements and processes for residents is defined and copies of EPoA were present in all residents' records. Staff were observed to obtain consent for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers	FA	Information on advocacy services is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the

<p>to advocacy/support persons of their choice.</p>		<p>entrance to the facility. Interviews with the relatives confirmed their understanding of the availability of advocacy (support) services. Posters regarding residents' rights were on view in both buildings and pamphlets on advocacy and support are available for family members and residents.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>All residents are assisted to maximise their potential for self-help and independence and to maintain links with their families. This is achieved through a variety of outings and visits and unrestricted visiting hours to encourage visits from residents' family members. All relatives interviewed stated they were made to feel welcome on entering the facility.</p> <p>The facility supports the philosophy of The Spark of Life and staff interviewed stated that they attempt to 'bring the light back into the resident's eyes' through meaningful and compassionate interaction and activities.</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>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that 11 complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager (FM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There has been one complaint to the Health and Disability Commissioner which met timeframes and has been resolved and closed out.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Families interviewed report being made aware of the Code and the Nationwide Health & Disability Advocacy Service through the admission process. Information is available for residents and family members and the Code was displayed prominently in both clinical areas.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents were observed to be treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with relatives were positive about the service in relation to their family member's values and beliefs being considered and met. Residents also expressed satisfaction; however this was expressed in line with their level of cognitive abilities and functioning. Residents' files and care plans identify residents preferred names. Information around values and beliefs is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and interdenominational church services are held. There is a policy on abuse and neglect and staff have received training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that resident's individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and supported within the service. They encourage active participation and input of the family/whānau in the day-to-day care of the resident. On the day of audit there was one resident who identified as Māori residing at the facility.</p> <p>Māori consultation is available through relationships with the local marae. Staff receive education on cultural awareness during their induction to the service and as a regular in-service education topic. Staff are also encouraged to learn and sing waiata in te reo Māori. There are guidelines for understanding the Māori culture as it relates to health.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Family members verified that the residents and the family were consulted on the resident's individual culture, values and belief systems and that they were respected by the staff. The family satisfaction survey demonstrated that all individual needs were being met as did the interview with family members.</p> <p>Combined inter-denominational church services are held on a fortnightly basis and residents who have identified spiritual or religious needs are assisted to attend.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	FA	<p>Interviews with family members demonstrated that they felt that residents were free from any type of discrimination, harassment, sexual, financial or other exploitation. The induction process for staff</p>

<p>harassment, sexual, financial, or other exploitation.</p>		<p>includes education related to professional boundaries, expected behaviours and the Code of Conduct. The registered nurse has records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service promotes evidence-based practice and encourages good practice. A registered nurse (RN) is available in person on weekdays and on call for the remainder of the week. A collaborative relationship is in place with a nearby facility to provide RN cover if the facility RN is on leave. Two general practitioners (GP) from the local health centre visit the facility regularly on a shared care basis and are on call for urgent matters. The GPs review residents identified as stable every three months, with more frequent visits for those residents who they view as being less stable.</p> <p>The GP interviewed confirmed the service sought appropriate medical intervention in a timely manner and were responsive to any medical requests.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist visits when deemed necessary. The service has links with the local community, plans regular community outings and encourages family members to remain in contact with their loved ones.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Family members stated that they were kept informed about any changes to their relative's health condition and were advised in timely manner about any incidents or accidents, such as falls or infections. The facility actively promotes family involvement and all family members are informed of the date and time of GP reviews and are contacted following a review to inform them of any changes to the medical or nursing care. This was supported in the residents' records that were reviewed and interviews with family members and the GP. Where English is the second language of a resident, the service has access to the DHB interpreter service and also utilises family members to interpret into the resident's native tongue.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of quarterly reports showed adequate information to monitor performance is reported including staffing issues, occupancy rates, identified risks and issues, trends and analyses of these.</p> <p>The service is managed by a facility manager (FM) and owner/registered nurse (RN) who hold relevant qualifications and have been in the roles for four years and 14 years respectively. Responsibilities and accountabilities are defined in job descriptions and individual employment agreement. The FM and owner/RN confirms knowledge of the sector, regulatory and reporting requirements and maintain currency through attendance at annual conferences and management related education forums.</p> <p>The service holds contracts with the DHB for rest home dementia care, respite, and one hospital level care resident. Thirty-seven residents were receiving services under the contract at the time of audit, including the one hospital and one respite resident.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the FM is absent, the owner/RN carries out all the required duties under delegated authority. During absences of owner/RN, the clinical management is overseen by an RN/manager from another facility who is experienced in the sector and able to take responsibility for any clinical issues that may arise. The arrangement is reciprocal and has worked very well for many years. Staff reported the current arrangements work well.</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>The service has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, and clinical incidents including infections and restraint use.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and staff meetings. Staff reported their</p>

		<p>involvement in quality and risk management activities through education and audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Family satisfaction surveys are completed annually. The most recent survey showed a high satisfaction in the activity programme and involvement of residents in outdoor activities.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at the quality and staff meetings.</p> <p>The FM and owner/RN both described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health or DHB since the previous audit.</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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates, where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for</p>

		<p>their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month induction/orientation period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The owner/RN is the internal assessor for the programme. Staff have either completed or are enrolled in the required education for services providing dementia care. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. A recent vacancy has occurred and recruitment is underway to find a replacement RN. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>An organisational staffing policy is in place to alter staffing according to the skill mix and residents' needs. Rosters are the responsibility of the FM with input from the owner/RN.</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Support staff reported there were adequate staff available to complete the work allocated to them. Family members interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable</p>

		<p>using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies, procedures and standard operating procedures in place around entry to services. The service provides an information pack on entry.</p> <p>The manager and RN assess all residents on entry to service. Initial information gained is paper based and is included in the resident records software package. The RN interviewed described the entry and admission process. The GP confirmed that he is notified of a new admission in a timely manner.</p> <p>Eight signed admission agreements were sighted and all had been signed. The agreement aligns to the service contracts and exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and coordinated manner. The service uses the DHBs 'yellow envelope' system to facilitate the transfer of residents to and from an acute service. There is open and transparent communication between the service and other services in addition to the resident's family/whānau. All referrals are documented clearly in the resident's progress notes. A file review of a resident transferred to the public health system showed a well-planned transfer and return to the service.</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>	PA Low	<p>The medication management policy and procedure clearly describe the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, process when an error occurs as well as definitions for 'over the counter' medications that may be required by residents. The sighted policies meet the legislative requirements and best practice guidelines.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in locked medicine trolleys in locked rooms when not in use. A locked</p>

		<p>cupboard is used for controlled medications. The service had no residents on a controlled drug at the time of audit. Evidence of pharmacy audits were sighted. Medications that require refrigeration are stored in a separate fridge.</p> <p>The 14 medicine charts reviewed have been reviewed by the GP every three months and this was recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (prn) medications identified had the reason stated for the use of that medication. There is a specimen signature register maintained for all staff who administer medicines. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident and a pharmacy medication/tablet identifying sheet. Resident photos were reviewed to ensure that the likeness remained current. Staff reported that residents do not self-administer medicines as they all have a degree of dementia.</p> <p>It was noted at time of audit that a herbal remedy was present in the medication trolley that was reported as being administered to residents but did not appear on any prescription sheet or the authorised standing order form. This requires a corrective action.</p> <p>The support partner administering medicines at the time of audit demonstrated competency related to medicine management.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The food service is provided on site by a cook and menu is in line with the recognised nutritional guidelines for older people. The menu is on a six week rotating cycle and was last reviewed by a dietitian on the 6 December 2012 with a suggested review date of September 2014. The menus were being audited by a registered dietitian but the completed dietary audit was not yet available.</p> <p>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal were sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and were sighted and meet the food safety requirements. Kitchen staff interviewed have a very good understanding of food safety</p>

		<p>management. It was observed that dried food had been decanted and labels were not present on all containers to indicate the product within, the decant date or the product expiry date. There was evidence that new stock had been emptied on top of old stock within the decanted containers. This requires improvement.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchens of both buildings to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>All meals are cooked and served directly from the kitchen at the time of the meal. Family/whānau interviewed reported that they are very satisfied with the food and fluid services.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but, following assessment by the FM and RN is deemed not to be appropriate, the local Needs Assessment and Service Coordination (NASC) service is advised to ensure that the prospective resident and family are supported in finding a suitable care alternative. If the needs of a resident changes and they are no longer suitable for the facility or the facility can no longer provide a level of care required for that resident's needs, NASC are contacted in consultation with the resident's family.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The facility has embedded the interRAI assessment protocols within its current documentation. InterRAI initial assessments and assessment summaries were evident in printed format in all files. The computer software includes a wide range of assessments that are used to develop the care plan. InterRAI assessments are also used to develop the individualised resident's care plans. All eight residents' files included an up-to-date interRAI assessment and computer-based assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The RN, support partners, GP and allied health providers documented their clinical and care notes in the paper based residents' files.</p> <p>All eight residents have a computer-based nursing care plan and a care plan summary in place. Assessments link to the care plan. The</p>

		<p>RN and support partners have free access to the residents' files. This was observed on the days of audit.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff.</p> <p>All resident care plans were individually focussed. All family members interviewed agreed that they had been involved, or were invited to be involved in the care planning development and review process.</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>	FA	<p>As observed on the day of the audit, the RN and support partners demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received, in line with the cognitive levels of residents within the facility. Family members stated that they were happy with the care provided and that the staff had a good knowledge and understanding of the specific and individual needs of the relative.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that were consistent with the resident's assessed needs and desired goals. The RN and support partners interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>The activities programme uses a framework to empower the residents, maintaining independence and is individually tailored to the needs of each resident. The residents are provided with opportunities that are of interest to them and are encouraged and supported to maintain their community and family friendships allowing for ongoing socialisation and developing new interests. The diversional therapists (DTs) adapts activities to meet the needs and choices of the resident. The facility has two DT's and three activities co-ordinator, two of whom aim to</p>

		<p>complete their DT training in 2017.</p> <p>The weekly activities plan/calendar sighted was developed based on the residents' needs and interests and can be easily adapted and changed depending on the residents' interest and reaction at the time. The diversional therapists advertise the upcoming activities on the calendar on the notice boards through the facility. The support partners assist with the planned activities. Regular activities include walks, newspaper reviews, community outings, exercise programmes, specific holiday themed events and use of the sunshine club room. Activities are individually planned for residents depending on their assessed cognitive level and specific individual need.</p> <p>All activities are planned and coordinated in line with the Spark of Life philosophy and include one to one sessions, involvement of family members and identification of individualised activities for each resident. The DTs and activity coordinator attend a bi-monthly support group and the North Canterbury Diversional Therapy meetings.</p> <p>The outside environment provides easy access to outside garden areas and there is a pathway linking both buildings. There are chickens in pens that residents can view and interact with. The enclosed garden area enable residents to come and go safely between buildings and allow for unrestricted wandering. There are seating arrangements and different areas for the focus of resident's attention.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements. Daily activities attendance sheet records are maintained for each resident. The goals are updated, assessed, reviewed and evaluated in each resident's file six monthly.</p> <p>Overall, the planned activities organised at Adriel Resthome continues to be maintained at a level of continuous improvement.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal. Care plans clearly state whether the goals had been met, were partially met or</p>

		<p>were not yet met.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or who are not responding to the services or interventions being delivered, are discussed with a GP and family/whānau. Short term care plans were sighted for wound care, infections, changes in food and fluid intake and skin care. The medical and nursing assessments of these short-term care plans were documented in the residents' progress notes.</p> <p>Family/whānau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition and they are notified in a timely manner by staff should a condition change or an unexpected event occur.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and/or their family/whānau are involved when referral to another service occurs. The RN interviewed described the referral process should they require assistance from specialist practitioners, including mental health, dental and ophthalmic services. The review of residents' folders included evidence of these referrals.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 3 April 2018 for both buildings) was publicly displayed.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities were fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio-</p>

		<p>medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. There are easily accessed outdoor areas that encourage purposeful walking.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required; any requests are appropriately actioned. Families interviewed state that they were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes separate facilities for staff and visitors. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	PA Low	<p>Residents' rooms are spacious enough to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents can occur and equipment can be transferred between rooms. Mobility aids can be managed in communal rooms.</p> <p>Rooms were observed to be personalised with furnishings, photos and other items and the service encourages residents to bring in personal items.</p> <p>There was room to store mobility aids such as walking frames safely.</p> <p>There are three double rooms in the facility. Only one of these rooms is shared with two residents, however, not all documentation for approved sharing has been completed as required. Family members of the double rooms were not available for interview.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining</p>	FA	<p>There are two separate buildings on the property. Each building is designed similar to the other. Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents</p>

needs.		can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. Families interviewed verified that the facility has sufficient space and residents may stay in their own areas or use any of the communal lounges.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	All laundry is completed on site in a spacious laundry. A survey of residents' family confirmed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. All chemicals sighted were labelled. Material safety datasheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning staff have completed chemical safety training.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 18 April 2014. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 12 December 2016. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted in both buildings and meet the requirements for residents and staff in each building. Water storage tanks are located around the complex, and there is a generator available if required. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and families reported staff respond promptly to call bells. There is at least one staff member on duty at all times with a first aid certificate.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Residents' rooms are provided with adequate natural light, ventilation, and an environment that is maintained at a safe and comfortable temperature. Temperatures are routinely monitored. Areas were warm and well ventilated throughout the audit and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p> <p>The infection control coordinator is the RN. The infection control coordinator holds accountability and responsibility for following the programme in the infection control manual. The infection control coordinator monitors for infections by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms and the monthly surveillance record. Infection control is discussed at each staff meeting and at the monthly quality meeting. If there is an infectious outbreak this is reported immediately to staff, management and where required to the DHB and public health departments.</p> <p>The infection control coordinator interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented and this is documented in the progress notes. Staff interviewed stated that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, staff communication book, one to one, shift handover and in residents' documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors to infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves were observed and found in all showers and toilets and gowns are easily accessed by staff as required. Residents who have infections are encouraged to stay in their rooms if</p>

		required.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The RN has the role of infection prevention and control coordinator. Infection control issues are discussed at staff and quality meetings and a report in the meeting minutes is available for staff who could not attend. The facility has the support of a clinical infection control specialist nurse, employed by the DHB, who is available for advice on infection prevention. Advice can also be sought from different external sources including the GP. The infection control coordinator has undertaken courses related to infection prevention through the district health board and other external sources including daily seminars. The registered nurse and support partners interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit, good hand washing technique was observed</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that support good infection control practice. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. The RN and support partners interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the RN. Infection control in-service education sessions are held.</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>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract, soft tissue, fungal, eye, gastro-intestinal, upper and lower respiratory tract infections. The infection prevention coordinator/RN reviews all reported infections and these are documented and reported.</p> <p>Monthly surveillance data that includes infection rates broken down by</p>

		<p>type is collated and analysed to identify any trends, possible causative factors and required actions. This is then reported in quality and staff meetings. If an increase in infection rates is identified, further data analysis is undertaken to identify the cause and implement remedial action. Infection control statistics are reported at every staff and quality meeting.</p> <p>The RN / infection control coordinator produces an annual quality report (sighted) that includes infection control statistics.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the owner/RN and provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, three residents were using restraints and no residents were using enablers. The restraint in use is hand holding during personal care tasks for all three residents.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval group, made up of the facility manager and owner/RN are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval meeting minutes, residents' files and interviews with the owner/RN that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with input from the resident's family/whānau/EPOA. The</p>

undertaken, where indicated, in relation to use of restraint.		RN interviewed/restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members.</p> <p>When a restraint is in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval meeting. The register was reviewed and contained all three residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraint is to be minimised and how to maintain safety when in use.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review	FA	The restraint committee undertakes a six-monthly review of all restraint

<p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>use which includes all the requirements of this Standard. Six monthly restraint meetings and reports were completed and individual use of restraint use was reported to the quality and staff meetings. Minutes of meeting reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the general practitioner, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with staff confirmed that the use of restraint has been reduced by three over the past six months. As well, the frequency of the use of restraint on all three residents has markedly reduced by at least 50 percent.</p>
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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	<p>The service has a documented medicines management system to manage the safe and appropriate prescribing, dispensing, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. During a check of the storage of medicines a herbal remedy was present in the medication trolley. This was reported by a staff person as being administered to residents but did not appear on any prescription sheet or the authorised standing order form.</p>	<p>One over the counter remedy was found in the drug trolley that was not prescribed for a resident, or included on the standing orders list approved for use within the facility.</p>	<p>Provide evidence that all medication administered is prescribed to comply with legislation, protocols and guidelines.</p> <p>90 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement,</p>	PA Low	<p>The service has ensured that all aspects of food procurement,</p>	<p>Dried food had been decanted and labels were not present on all</p>	<p>Provide evidence that all aspects of food</p>

<p>production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>		<p>production, preparation, transportation, delivery, and disposal comply with current legislation, and guidelines. However, upon audit, it was evident on observation and during staff interview that decanting of food had occurred. The decanted food was not identifiable or labelled correctly.</p> <p>A menu review was last conducted in December 2012. The current menu had not been reviewed by an appropriate person since this date.</p>	<p>containers to indicate the product within, the decant date or the product expiry date. There was evidence that new stock had been emptied on top of old stock within the decanted containers.</p> <p>The last dietitian's audit of the menu had taken place on 6 December 2012 with a suggested review date of September 2014. Although the menu had been sent for a dietitian review, this review was not available at the time of audit.</p>	<p>safety management, including storage and menu review, meets current legislation and best practice guidelines.</p> <p>180 days</p>
<p>Criterion 1.4.4.1</p> <p>Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.</p>	<p>PA Low</p>	<p>There are three double rooms in the facility. Only one of these rooms is shared by two residents. One resident's family has approved the shared room, however, the other resident's family has not and other required documentation has not been completed. The rooms were observed to be spacious for both residents to move comfortably including with assistive aids.</p>	<p>Two residents share a double room. Documentation as required in E3.3b/c has not been completed. Approval for sharing from one resident's family has not occurred. This family member has not been in contact with the resident until recently. There is no documented approval from the District Health Board.</p>	<p>When two residents share a room, there is documented approval for this to occur as required in E3.3b/c.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<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 continues to implement the Spark of Life philosophy and has two thirds of its staff trained via the three-day Spark of life practitioners' course consisting of 18 hours of training. These staff are referred to as 'torch bearers'. The facility also includes the philosophy into the induction programme for new staff, utilising a descriptive appreciation approach for all residents. The Beyond Boundaries model has also been adopted into policy for the service. Challenging behaviours are viewed by staff as being a result of unmet need and staff are taught to manage these behaviours through the use of individualised activities, resulting in a demonstrated reduction of psychotropic medication use, a reduction in the use of personal restraint and an overall reduction in challenging behaviours displayed by the residents. This was demonstrated by document reviews of residents' notes, interRAI reports and interviews with staff members. It was observed through resident case note review that activity plans were reviewed and adapted on an</p>	<p>The service is rated continuous improvement for the continued use of the Spark of Life philosophy and the positive impact it has on the lives of residents living at Adriel Resthome.</p>

		individual basis as a result of regular evaluation of the activities programme. The RN also ensured that the overall programme remained flexible and dynamic, adaptations being made in correlation to resident responses and progress.	
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End of the report.