

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

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 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); Dementia care

Dates of audit: Start date: 5 March 2018 End date: 6 March 2018

Proposed changes to current services (if any): The service is currently certified for residential disability- physical level care. This is not documented in the 'services audited' table below. Residential disability – physical was audited as part of this certification audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 107



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 Lifecare is part of the Arvida Group. The service is certified to provide rest home, hospital (medical and geriatric), dementia and residential disability – physical level care for 109 residents. At the time of the audit there were 107 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff, management and general practitioners.

The village manager (RN) has been in the role for one year and has many years' experience in managing health care services. He is supported by an experienced clinical manager. Family and residents interviewed all spoke positively about the care and support provided.

There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisations quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There is one improvement required around medication documentation.

Two continuous improvement ratings have been awarded around restraint minimisation and community involvement.

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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Staff at St Allisa Lifecare strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). The service promotes the attitude of living well (wellness) and introduction of the household model. Younger people are supported to remain involved in the community. Residents' cultural needs are met. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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St Allisa Lifecare has a current strategic plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies. Quality projects are implemented. Quality data is reported to the quarterly combined staff and monthly quality meetings. There is an annual internal audit calendar schedule. Residents and relatives are provided the opportunity to feedback on service delivery issues at monthly resident meetings and via annual satisfaction surveys. The introduction of the wellness meeting has given the residents a strong voice into how the facility should be run. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. The service has an orientation programme in place that provides new staff with relevant

information for safe work practice. The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

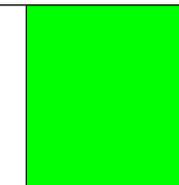
Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. InterRAI assessments are utilised and link to care plans. Care plans viewed demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. The medicine charts were reviewed at least three-monthly by the general practitioner.

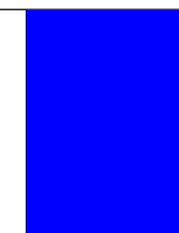
An integrated activity programme is implemented for residents. The programme includes community visitors and outings, entertainment and activities that meet the individual physical, cultural and cognitive abilities and preferences for each resident group. Residents and families report satisfaction with the activities programme. Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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St Allisa Lifecare has a current building warrant of fitness. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with ensuites. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

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.		All standards applicable to this service fully attained with some standards exceeded.
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St Allisa Lifecare has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. At the time of the audit, the service had two residents using restraints and no residents using any enablers. A registered nurse is the designated restraint coordinator. Assessed risks are documented in care plans. Ongoing restraint assessments, monitoring and evaluation occurs. The service and organisation regularly review restraint use and strive to minimise the use of restraint.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	2	47	0	1	0	0	0
Criteria	2	98	0	1	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with sixteen care staff (eight caregivers, five registered nurses (RN) and three diversional therapists) confirm their familiarity with the Code. Interviews with twelve residents (nine rest home, one hospital and three younger persons) and eight families (four rest home, one hospital and three dementia care) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings. Staff receive training on the Code, last occurring in July 2017</p>
<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</p>	FA	<p>Informed consent processes were discussed with residents (as appropriate) and families on admission. Written general and specific consents were evident in the 12 resident files reviewed (five rest home including one YPD, five hospital including two YPD, and two dementia). Caregivers and RNs interviewed confirm consent is obtained when delivering cares. Advance directives identified the resident resuscitation status. Advance directives had been appropriately signed by the resident and general practitioner (GP). Copies of EPOA are contained within the resident file where appropriate. Discussion with eight family members (three from dementia, four rest home, one hospital) identified that the service actively involves them in decisions that affect their relative's lives. Interviews with two YPD residents (hospital) both felt fully informed. Eleven signed admission agreements were sighted in the long-term resident files reviewed.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy, last occurring in July 2017. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.</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>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents and relatives interviewed confirmed that relative/family visiting could occur at any time.</p> <p>Residents on the YPD contract are engaged in a range of diverse community activities including (but not limited to) going out to church, craft group, RSA and going to the library.</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>	FA	<p>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. Five complaints (four in 2018 year to date and one in 2017) have been received at St Allisa Lifecare since the last audit. The complaints reviewed have been managed appropriately with acknowledgement, investigations and responses recorded. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the village manager or clinical manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code.</p>
Standard 1.1.3:	FA	The service has policies that align with the requirements of the Privacy Act and Health Information Privacy

<p>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>		<p>Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. There is a policy that describes spiritual care. Church services are conducted regularly. Residents interviewed indicated that resident's spiritual needs are being met when required. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity.</p> <p>Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity.</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 has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan in place. There were two residents that identified as Māori at the time of the audit. One file of a resident identified as Maori was reviewed, the file included a specific Maori health care plan. The service has established links with the local Iwi. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process. Discussions with the caregivers confirm that they are aware of the need to respond to cultural differences.</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>The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness, last occurring in January 2017.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other</p>	FA	<p>The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>

exploitation.		
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Policies also take into consideration younger people with disabilities. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p> <p>Arvida is operationalising their vision 'to transform the ageing experience' within the care communities through the introduction of the wellness/household model. The wellness/household model focuses on the relationship between the care team and the resident as partners in the pursuit of a rich and meaningful life. St Allisa Lifecare introduced the wellness/household model in July 2107 (Link 1.3.7.1). The emphasis is on supporting each resident to live well and be actively engaged in their life the way they want it to be. Residents are supported within the care communities by decentralised self-led teams of employees that together create home, nurture relationships, determine their own lives and build community. Residents are encouraged and supported to create a comfortable living space suited to their particular needs and personal tastes. A wellness leader has been introduced January 2018. The introduction of the wellness meeting has given the residents a strong voice into how the facility should be run.</p> <p>The registered nurse restructure in March 2017 has introduced clinical leads providing leadership to staff. Sharing of clinical expertise enhancing health outcomes for residents. Overall there has been an increase in RN hours for the facility.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twelve incident/accidents (four hospital, five rest home and three dementia level of care) forms reviewed for January and February 2018 had documented evidence of family notification or noted if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. Residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Interpreter services are available as required. St Allisa Lifecare has a number of younger people including residents on YPD contracts. These residents' communication methods are available through social media and networks. Wifi is available for residents.</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>St Allisa Lifecare is part of the Arvida Group. St Allisa Lifecare provides care for up to 109 rest home, hospital (geriatric and medical), residential disability - physical and dementia level care residents.</p> <p>On the day of audit, there were 107 residents in total across six wings. There were two residents on a close in interest contract and one resident on a mental health contract, one resident on respite in the dementia unit. There were 11 younger persons (eight rest home and three hospital level). All other residents were on the aged related residential care (ARRC) agreement</p> <p>Five of the wings are dual-purpose.</p> <p>In Ashley wing (19-beds), there were 18 hospital residents including two YPD (hospital level). In Waiiau wing (10-beds), there were six hospital and four rest home residents including two YPD resident (one rest home level and one hospital level).</p> <p>In Rakaia wing (25-beds), there were 19 rest home and five hospital residents. In Selwyn wing (14-beds), there were 13 rest home (including six YPD) residents and one hospital resident in the upstairs wing. In the upstairs Hurunui wing (21-beds), there were 21 rest home residents (including one YPD).</p> <p>In the Waimarie wing (20-bed secure dementia unit) there were 20 residents including one respite.</p> <p>There is a village manager (RN) who has been in the role for one year. He is supported by an experienced clinical manager who has been in the position since October 2015, and has worked at St Allisa Lifecare for over five years. The village manager and clinical manager are supported by the general manager operations, general manager wellness and a national quality manager (who was present on the days of the audit).</p> <p>The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. St Allisa Lifecare has a business plan for 2018 and a quality and risk management programme. The business plan identifies the future provision of hospital and medical services.</p> <p>The village manager and clinical manager have completed in excess of eight hours of professional development in the past 12 months.</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</p>	<p>FA</p>	<p>In the absence of the village manager, the clinical manager is in charge. Support is provided by the general manager operations, the general manager wellness and care, and the care staff.</p>

<p>efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</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>There is a 2018 business/strategic plan that includes quality goals and risk management plans for St Allisa Lifecare. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager is responsible for providing oversight of the quality programme on site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. The site-specific service's policies are being transitioned over to the Arvida Group polices, which will be reviewed at least every two years across the group. Head office sends new/updated policies. There are policies and procedures appropriate for service delivery including the specific needs of younger people. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed.</p> <p>Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system that is regularly reviewed. Restraint and enabler use (when used) is reported within the quality and clinical staff meetings. 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. All staff interviewed could describe the quality programme corrective action process. Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee.</p> <p>The health and safety committee has been recently changed to have more representative membership, six representatives have received specific health and safety training in their role. Hazard identification forms and a hazard register are in place. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The May 2017 resident relative survey overall result shows satisfaction with services provided. The results for the resident/relative satisfaction survey completed in February 2018 have not yet been evaluated. Surveys include young people with disabilities around issues relevant to this group. Resident/family meetings occur monthly and resident and families interviewed confirmed this. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Twelve incident</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>forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for any reviewed unwitnessed falls with potential head injuries. Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been four section 31 incident notifications required since the last audit. There were three notifications for missing persons (November 2017, in January and February 2018) and one for a pressure injury (stage four) in April 2017. All were well managed and documented.</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>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Ten staff files were reviewed (one clinical manager, three RNs, four caregivers, one diversional therapist and one kitchen manager). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in eight of ten staff files reviewed; the other two staff were new to the service. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme.</p> <p>The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. Discussions with the caregivers and the RNs confirmed that on-line training through the aged care channel is available. Eight hours of staff development or in-service education has been provided annually. There are 13 RNs and seven have completed interRAI training. Arvida has introduced an aged care channel online training for staff.</p> <p>There are ten caregivers who work routinely in the dementia unit and eight have completed the dementia standards. The remaining two caregivers are in progress of completing. The Arvida group hosts two conferences per year for village managers and clinical managers to promote the updating of skills and knowledge. The service had 31 staff attend a wellness education session in May 2017, which was relevant to physical disability and young people with physical disabilities.</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</p>	<p>FA</p>	<p>St Allisa Lifecare policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 90 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager (RN) and clinical manager work 40 hours per week from Monday to Friday and are available on call after hours. In addition to the village manager and clinical manager there is at least one RN on at any one time. The RN on each shift is aware that extra staff can be called on for increased resident requirements.</p> <p>In the hospital wings on the ground floor (Ashely 19 beds and Waiau 10 beds) there were 18 hospital</p>

<p>providers.</p>		<p>residents in the Ashley unit and six hospital and four rest home residents in the Waiau wing. There is one RN on duty in the morning shift and afternoon shift, and night shift. They are supported by six caregivers on the morning shift, and on the afternoon shift and two caregivers on the night shift.</p> <p>In the rest home wings on the 1st floor (Selwyn 14 beds, Hurunui 21 beds and Rakaia 25 bed wings) there was one hospital and 13 rest home residents in the Selwyn unit, 21 rest home residents in the Hurunui unit and five hospital and 19 rest home residents in the Rakaia wing. There is one RN on duty in the morning shift and on the afternoon shift. They are supported by six caregivers on the morning shift, three on the afternoon shift and one caregiver on the night shift.</p> <p>In the dementia (Waimarie 20 beds) there were 20 dementia care residents. There is one RN on duty in the morning shift, supported by three caregivers on the morning shift, and on the afternoon shift and one caregiver on the night shift. The RNs from the hospital cover the rest home on the night shift and the dementia unit on the afternoon and night shifts.</p> <p>Interviews with staff, residents and family members confirm there are sufficient staff to meet the needs of residents. The caregivers interviewed stated that they have sufficient staffing levels.</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>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations and password protected on computers. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregiver or RN.</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>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed align with all contractual requirements and kept within the electronic file. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition,</p>	<p>FA</p>	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to</p>

<p>Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service. The yellow transfer envelope is used for acute admissions to hospital.</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 safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs, enrolled nurses and senior caregivers) have been assessed for competency on an annual basis. Annual education around safe medication administration has been provided. Registered nurses complete syringe driver training. Two-weekly delivery of blister packs are checked against the medication charts by the RNs on night-shift, as evidence on the signing sheet. Medication fridges are checked daily and are maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were no residents self-medicating. Twenty-two medication charts were reviewed across the six wings. All had photo identification, allergy status and had been reviewed by the GP at least three-monthly. As required medication had indications for use. Younger people are supported to self-administer medications when appropriate. Residents self-administering medication had three-monthly competencies completed. Standing orders had been signed per medication by both GP's.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>St Allisa has a commercial kitchen where all food is prepared and served. The service employs three cooks and five kitchen-hands. All have completed food safety certificates. The cook interviewed explained the procurement of the food and management of the kitchen, for which she is responsible.</p> <p>The service has two separate sittings for meals. One sitting for residents' requiring assistance and one sitting for more independent residents. This process was observed and there were sufficient staff to assist with smooth transitions between sittings.</p> <p>In the dementia unit, meals are served in the unit dining room from the bain marie. 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. There is a food control plan in place (yet to be audited).</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. Special diets were noted on the kitchen noticeboard.</p> <p>Nursing staff complete a daily resident preference (two choices offered for main dinner served at midday).</p>

		<p>The menu is a four-weekly seasonal menu. Residents and families interviewed, overall stated satisfaction with the food. Dietary supplements are available. The dietitian reviewed the menu in 2017.</p> <p>As per contract requirements, snacks are available to residents in the dementia unit 24/7.</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>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</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 RN completes an initial assessment on admission including risk assessment tools. A long-term care plan is completed within 21 days of admission and thereafter six-monthly, or earlier due to health changes. Eleven of 12 files (including two of three YPD files) reviewed identified interRAI assessment notes and summaries were available. The other YPD file included a range of assessment tools. The outcomes of assessment tools are linked to the long-term care plan. Two files of residents in the dementia unit (including one respite) included behaviour assessments that linked to behaviour charts. The resident needs, goals and supports are documented in the long-term care plans.</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>Resident care plans reviewed (electronic) were resident focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and are generated on the electronic system. Three YPD resident files reviewed included individual personal goals. The respite file reviewed in the dementia wing included a short-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. There was evidence of allied health care professionals involved in the care of the resident including the GP, physiotherapist, mental health team, speech language therapist, podiatrist, hospice and dietitian.</p>
<p>Standard 1.3.6: Service</p>	FA	<p>When a resident's condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>evidences family were notified of any changes to their relative's health including (but not limited to): accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Adequate dressing supplies were sighted in treatment room. Registered nurses were regularly involved in resident daily care and ongoing assessments as identified in the progress notes. A weekly evaluation is completed by the RNs.</p> <p>Wound management policies and procedures are in place. A sample of four wounds records were reviewed including the two current pressure injuries (one grade two, one grade one). Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for all residents with wounds. The service can access the DHB wound nurse specialist if required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. There is dietitian involvement where required.</p> <p>Monitoring occurs for weight, blood pressure, blood sugar levels, pain, neurological observations, food and fluid charts. These were sighted across the files reviewed. The RN monitors and reviews the monitoring forms daily on the electronic system. Care staff report any changes to the RN.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The service employs a team of four diversional therapists (DTs). There are activities scheduled across seven days in the dementia unit and upstairs and downstairs rest home/hospital five days a week. The DTs working in the dementia unit have completed dementia standards.</p> <p>The integrated programme offers choice and variety of activities for residents to attend including, crafts, board games, card games, newspaper reading, exercises indoors and outdoors" and bowls. There are three different planners that go up on the noticeboards in all areas and residents also get an individual copy.</p> <p>There are a number of one-on-one activities for residents not involved in group activities. There are a number of resident-led groups including craft group, knitting group, garden group and walking group. There is a van that goes out 3x weekly and includes outings for all resident groups. A mobility van is hired monthly. are weekly outings for rest home residents and a mobility van is hired monthly for hospital residents. There are regular outings for drives and attending community events and inter-home visits.</p> <p>Community visitors to the facility include entertainers, canine therapy, pre-school dancers and church visitors for regular interdenominational and Catholic church services. Rest home residents in the serviced apartments are invited to participate in the activities in the care centre. A resident profile "About Me" is completed on admission. Individual leisure activity plans were seen in all resident files reviewed. The DT is involved in the six-monthly multidisciplinary review. The service receives feedback and suggestions for the programme through resident meetings and surveys. Residents interviewed were happy with the activity</p>

		<p>programme.</p> <p>There is a Wellness meeting and resident delegates from each wing are part of this meeting. They provide feedback in the activity programme. Regular one-on-one meetings with the younger residents assists in ensuring activities are planned to meet the needs of these residents. Younger person specific activities include (but are not limited to), involvement with local community, attending craft group, going out to play pool, library visits and attending church in the community. There is WIFI available for residents. Three (YPD) residents interviewed confirmed that they have individualised choices in activities and are supported to stay involved in the community.</p> <p>The diversional therapists complete an activity assessment on admission and develop have input into two sections of the electronic care pal "in leisure and pastoral care'. There was a 'diversional behaviour distractions' plan for the resident file reviewed in the dementia unit that linked to the 24-hour activity plan.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the multidisciplinary team at least six-monthly or earlier for any health changes. InterRAI re-assessments have been completed 6-monthly in support of reviewing the care plan. All care plans have recently been updated and transferred to the electronic programme. As part of the review and update of the care plans an evaluation has been completed. Each section of the care plan is evaluated. Family are invited to attend the 6-monthly MDT review and informed of any changes if unable to attend. The MDT meeting (now called Case Conference checklist on the electronic system) includes a holistic evaluation of care and support including input from allied health and medical staff. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes and short-term care plans are established where required. Changes to the electronic long-term care plan identify name and date to reflect the update. Residents and relatives interviewed confirmed involvement in the Case Conference and evaluation of the care plan.</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</p>	FA	<p>Referral to other health and disability services is evident in the resident files sampled. Examples include (but not limited to) referral for rest home resident to a community occupational therapist for modified utensils and chair, one rest home resident for speech language therapist and reassessment for higher level of care, referral to community physiotherapist for adjustments to specialist wheelchair for YPD resident, referral to dietitian for the respite resident. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>

appropriately facilitated, or provided to meet consumer choice/needs.		
<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>There are policies and procedures in place for waste management. Residents, staff and visitors are protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. Product use information is available. Protective equipment including gloves, aprons, and goggles are available for use by staff. Staff interviewed were familiar with accepted waste management principles and practice.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The facility has a current building warrant of fitness, which expires on 1 March 2019. The maintenance person works full time and completes annual scheduled maintenance tasks. Assessment for hot water temperatures checks are conducted monthly. Hot water temperatures have been tested and recorded monthly with readings below 45 degrees Celsius. Essential contractors are available 24 hours. Corridors are wide in all areas to allow residents to pass each other safely. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. The facility is on two levels. The upstairs floor area can be accessed by two flights of stairs and a lift. Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors. The exterior by the entrance is well maintained with safe paving, outdoor shaded seating, lawn and gardens and car parking. Interviews with the caregivers confirmed that there was adequate equipment to carry out the cares according to the resident's care plans.</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</p>	FA	<p>All resident rooms have full ensuite facilities. There are also sufficient communal toilets adjacent to the lounge and dining areas. Refurbishment has been completed on two wings since previous audit. The number of visitor and resident communal toilets provided is adequate. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use signs.</p>

hygiene requirements or receiving assistance with personal hygiene requirements.		
<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>	FA	The rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. Bedrooms are personalised, and residents interviewed stated they enjoyed their rooms.
<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 needs.</p>	FA	There is a large lounge and dining room on both floors and small seating areas which are used for activities, recreation and dining activities. The dining room downstairs is spacious, and located directly off the kitchen/server area. Due to the number of residents, meals are completed in two shifts. Residents and staff interviewed said this works well and there is also flexibility. Residents that are being fed tend to be on one shift. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed report they can move around the facility and staff assist them if required. The dementia unit has a dining room and a half wall separates the lounge area from the dining room without being two separate rooms. Both areas allow for activity and individual time.
<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	There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the designated laundry staff. There is a dirty and clean entrance. Staff attend infection prevention and control education and there is appropriate protective clothing available. Cleaners are employed seven days a week. Manufacturer's safety data charts are available for reference if needed in an emergency. Residents and family interviewed report satisfaction with the laundry service and cleanliness of the facility
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	FA	There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 1 February 2018. There is an approved evacuation plan in place. All RNs hold a current first aid certificate. A contracted service provides checking of all facility equipment including fire equipment. Fire

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. Short-term backup power for emergency lighting is in place. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and two gas BBQ's for alternative cooking. Emergency food supplies sufficient for three days are kept in the kitchen. There is a store cupboard of supplies necessary to manage a pandemic/outbreak. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The facility is secured at night. The service utilises security cameras.</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>All communal and resident bedrooms have external windows with plenty of natural sunlight. The facility is heated by a mix of wall panels and heat pumps. Windows and ranch sliders open for ventilation. The general living areas and resident rooms were appropriately heated and ventilated on the day of audit. Residents and family interviewed state the environment is comfortable.</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>An RN is the infection prevention and control officer. There is a job description that outlines the responsibility of the role. The infection prevention and control officer is supported by the infection control committee and quality committee. Infection control data is reported to staff and management including head office. The infection control programme has been reviewed annually at the head office by the general manager wellness and also through the quality committee. Visitors are asked not to visit if they are unwell. Hand sanitizers were appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks since previous audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	<p>FA</p>	<p>The infection prevention and control officer has completed an infection control paper through the local nursing school. The infection control committee are representatives from each area. Relevant personnel are invited to committee meetings as applicable. Infection control is also an agenda item of the quality committee. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection prevention and control officer and infection control committee have good support from the Arvida Group head office, the infection control nurse specialist at the DHB,</p>

infection control programme and meet the needs of the organisation.		external consultants, laboratory technician and GPs.
<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>There are Arvida Group infection control policies and procedures that are appropriate for the size and complexity of the service. The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.</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>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred annually and was recently completed by an IP&C nurse consultant. Hand hygiene audits are completed as part of the internal audit programme. All staff complete infection control orientation and questionnaires on employment. Information is provided to residents that is appropriate to their needs and this is documented in clinical records and resident meetings (as applicable).</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>Infection surveillance is an integral part of the infection control programme and is described in the Arvida Group infection control manual. Monthly infection data is collected for all infections based on standard definition of signs and symptoms of infections. Short-term care plans are used for infections. Surveillance of all infections is entered into the monthly online infection control register. Head office can monitor current infections. This data is monitored and evaluated monthly, six-monthly and annually. Trends and analysis of infections and corrective actions are discussed at quality and infection control committee meetings. Meeting minutes and graph are available to all staff. Benchmarking occurs within the Arvida Group.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised and have intentionally minimised restraint use (link 2.5.5). Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. At the time of the audit, the service had two residents using restraints (lap belts) and no residents using any enablers. Restraint minimisation is overseen by a restraint coordinator (RN). The RN states that any restraint would be used only when absolutely necessary and as a last resort. Staff education on restraint minimisation and management of challenging behaviour has been provided in March 2017.</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 process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Ongoing consultation with the resident and family/whānau are evident. The files for the two residents using restraint were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h). Falls risk assessments are completed six-monthly and interRAI assessment identifies risk and need for restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. The care plan reviewed of two residents with restraint, identified observations and monitoring. Restraint use</p>

		is reviewed through the monthly assessment evaluation, monthly restraint meetings and six-monthly multidisciplinary meeting which includes family/whānau input. A restraint register is in place, providing a record of restraint use and is completed for residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred monthly as part of the ongoing reassessment for the residents on the restraint register and as part of their care plan review. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	CI	An RN is the restraint coordinator and reports to the quality team on a regular basis. Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the regional restraint approval group teleconference meeting and information is disseminated throughout the organisation.

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	Twenty-two medication charts were reviewed across the six wings. All had photo identification, allergy status and had been reviewed by the GP at least three-monthly. Twenty-two signing charts reviewed identified medication had been signed as given in 21 of the charts.	One hospital resident was due a Norspan patch controlled drug (3/3/18), this had not been given or followed up.	<p>Ensure medication is given as prescribed or reason why not given documented.</p> <p>30 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>Arvida is operationalising their vision ‘to transform the ageing experience’ within the care communities through the introduction of the wellness/household model. The wellness/household model focuses on the relationship between the care team and the resident as partners in the pursuit of a rich and meaningful life. St Allisa Lifecare introduced the wellness/household model in July 2107. The emphasis is on supporting each resident to live well and be actively engaged in their life the way they want it to be. Residents are supported within the care communities by decentralised self-led teams of employees that together create home, nurture relationships, determine their own lives and build community. Residents are encouraged and supported to create a comfortable living space suited to their particular needs and personal tastes. A wellness leader has been introduced January</p>	<p>St Allisa has introduced resident led initiatives towards the organisations Wellness model. The approach to resident-led activities and the Wellness model has increased improvement in resident involvement. The service could give examples of where residents initiate activities themselves and also involvement in health & safety. This intentional involvement as provided more of a voice and empowerment for residents. Examples of wellness initiatives introduced (but not limited to); one resident is the H&S resident representative, one resident commenced a bridge club and teaches others how to play bridge in the weekends, one resident runs a Tai Chi</p>

		2018. The introduction of the wellness meeting has given the residents a strong voice into how the facility should be run	class and two residents provide assistance with maintenance tasks, and three residents involved in recruitment interviews.
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	CI	<p>At the restraint committee meeting in June 2017 the service chose to actively work at reducing restraint and enabler use. The service works within the standards to minimise the restraint use. Restraint is only used as a last resort, following alternate interventions.</p>	<p>An RN is the restraint coordinator and reports to the quality team on a regular basis. The service has actively worked to promote and reduce the use of restraint. This approach has been supported by management with investment in alternatives such as sensor mats, low beds and landing mats. Family/whanau have been actively involved in seeking alternatives options to ensure resident wellbeing and safety. The facility has reduced from six residents identified as requiring a restraint or an enabler (four residents with restraint and two using an enabler) in June 2017 to two residents using lap belt restraints in March 2018.</p>

End of the report.