

Ilam Lifecare Limited - Ilam Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Ilam Lifecare Limited
Premises audited:	Ilam 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: 4 July 2018 End date: 5 July 2018
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:	87

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
Yellow	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
Red	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

Ilam Lifecare is part of the Arvida Group. The service is certified to provide rest home, hospital and dementia level care for up to 76 residents across the care centre and up to 47 residents at rest home level of care in studio apartments. On the day of the audit there were 87 residents.

This unannounced surveillance audit was conducted against a subset of the health and disability services standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family member, general practitioner, staff and management.

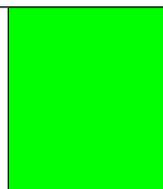
The village manager has been in the role 18 months. The service has an experienced clinical manager/registered nurse. The relatives, residents and general practitioner interviewed all spoke positively about the care and support provided at Arvida Ilam Lifecare.

The one previous finding around care plan interventions has been addressed.

The service has maintained a continuous improvement rating for activities.

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.

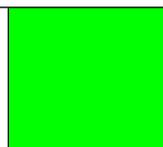


Standards applicable to this service fully attained.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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.

Ilam Lifecare is implementing a quality and risk management system that supports the provision of clinical care. Business/strategic plan goals provide direction. The service is run by a suitably qualified village manager and clinical manager who are responsible for the day-to-day operations of the facility. The village manager and clinical manager are supported by four charge nurses. Quality activities are conducted which generates opportunities for improvement. Corrective actions are developed and implemented. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

All standards applicable to this service fully attained with some standards exceeded.

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. Care plans viewed demonstrated service integration and were evaluated at least six monthly. InterRAI assessments are utilised. Resident files included medical notes by the general practitioner and visiting allied health professionals.

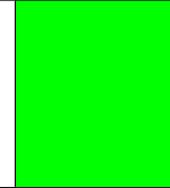
Medication policies reflect legislative requirements and guidelines. Registered nurses and care staff responsible for administration of medicines complete education and medication competencies. The medicine charts were reviewed at least three monthly by the general practitioner.

An integrated activity programme is implemented for all rest home residents (including studio apartments) and hospital level of care. 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.

All meals are cooked on-site. Residents' food preferences and dietary requirements are identified at admission. 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.

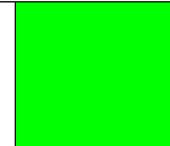


Standards applicable to this service fully attained.

The building holds a current warrant of fitness.

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.

The service has policies and procedures to ensure that restraint is a last resort. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. At the time of the audit there were five residents with six restraints and one resident using an enabler. The file for the resident with an enabler showed that enabler use is voluntary. Staff receive training in restraint minimisation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The 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	1	16	0	0	0	0	0
Criteria	1	42	0	0	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 1.1.13: 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 that describes the management of complaints process. There is a complaint form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaint register. There have been eight complaints made in 2017 and six complaints received in 2018 year to date. All complaints reviewed had noted investigation, timeframes and corrective actions when and where required, resolutions were in place. Results are fed back to complainants. A complaint made to the Health and Disability Commission in March 2018 was investigated with corrective actions put in place (evidenced) and resolutions completed. A letter from the Health and Disability Commission in May 2018 confirmed that no further action would be taken.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Full information is provided on admission for residents and family/whānau. Seven residents (four hospital and three rest home) interviewed, confirmed they were given an explanation about the services and procedures and that their cultural needs are being met. Management have an open-door policy. 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 had documented evidence of family notification or noted if family did not wish to be informed. Four family members (two hospital, two rest home including one in the serviced apartments) interviewed, confirmed that they are notified of any changes in</p>

<p>environment conducive to effective communication.</p>		<p>their family member's health status and are involved in the resident's care planning. Interpreter services are available as required.</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>Ilam Lifecare is owned and operated by the Arvida Group. The service is certified to provide rest home, hospital (medical and geriatric) and dementia level care in dedicated purpose-built wings for up to 123 residents including rest home level care across 22 rest home beds, hospital level care across 34 hospital beds; and dementia level care across 20 dementia beds, and 47 certified serviced apartments certified to provide rest home level care. Seven rest home beds have been assessed as suitable for dual-purpose. On the day of the audit occupancy was 87 residents in total including 22 rest home residents, 15 rest home residents in the serviced apartments, including one resident on respite care, 30 hospital residents and 20 dementia care residents. All residents were admitted under the aged related residential care contact (ARRC).</p> <p>The village manager (non-clinical) is experienced in village management. The village manager manages both the Ilam Lifecare and Maples Lifecare facilities. He has been in the village manager role at Ilam Lifecare from January 2017 and at Maples Lifecare since April 2018. The village manager is rostered to spend two and a half days of the week at each village (Ilam Lifecare and Maples Lifecare). He is supported by a clinical manager who has been in the position for six years and worked at Ilam Lifecare for 13 years. The village manager and clinical manager are supported by four charge nurses across the rest home, hospital, dementia unit and in the serviced apartments.</p> <p>The village manager and clinical manager are also supported by the general manager operations, general manager wellness and a national quality manager. 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. Ilam Lifecare has a business plan for 2016–2018. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually.</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 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>There is a business plan that includes quality goals and risk management plans for Ilam 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 an organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. Staff interviewed could describe the quality programme corrective action process. The site-specific service's policies are reviewed at least every two years across the group. Head office sends new/updated policies. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>safety management system that is regularly reviewed. Restraint and enabler use is reviewed at the monthly quality committee meeting.</p> <p>Health and safety goals are established and regularly reviewed at the village manager's monthly teleconference meeting. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored at the monthly quality and risk committee meeting. Hazard identification forms and an up-to-date hazard register (last reviewed in June 2018) are in place. Resident/family meetings occur six monthly and the residents and family members interviewed confirmed this. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The overall service result for the resident/relative satisfaction survey completed in March 2018 was at 78%. Corrective actions have been established in areas where improvements were identified. Corrective actions have been completed and signed off. 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>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>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 quality and risk committee, and staff meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Twelve incident forms (four hospital, four rest home and four dementia) reviewed for June 2018, demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for seven unwitnessed falls reviewed.</p> <p>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. Since the last audit there were appropriate notifications documented relating to four section 31 notifications to the Ministry of Health (one stage three pressure injury in April 2017 and one unstageable pressure injury in May 2018, and two missing residents in April and August 2017). One outbreak of norovirus was also notified to public health in May 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	<p>FA</p>	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires relevant checks are completed to validate the individual's qualifications, experience and veracity. Six staff files were reviewed (one clinical manager, two charge nurses, two caregivers and one diversional therapist). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. 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.</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</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 ongoing training is encouraged and supported by the service. More than eight hours of staff development or in-service education has been provided annually. There are fourteen RNs and five have completed interRAI training. There are eleven caregivers who work in the dementia units with seven caregivers having completed the required dementia standards. Four caregivers are in progress of completing and have all commenced work within the last 12 months.</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>Human resources policies include documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 100 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager is rostered to spend two and a half days of the week at both Ilam Lifecare and Maples Lifecare. The clinical manager works 40 hours per week from Monday to Friday. The village manager and clinical manager are available on call after hours. There is a charge nurse in the rest home unit, hospital unit, dementia unit and serviced apartments. The charge nurses are aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirmed there are sufficient staff to meet the needs of residents. The caregivers interviewed confirmed that they have sufficient staffing levels.</p> <p>The service is divided across four units; across the two hospital units (Charlotte Jane) there are 30 of 34 hospital residents in total. There is one charge nurse/RN on duty in the morning and afternoon shifts, and one RN on the night shift. They are supported by seven caregivers (four long and three short shifts) on the morning shift, six caregivers (two long and four short shifts) on the afternoon shift and two caregivers on the night shift.</p> <p>In the rest home unit (Randolph) there are 22 of 22 residents in total. There is one charge nurse/RN on duty in the morning shift. The RNs from the hospital unit cover the afternoon and night shifts. They are supported by two caregivers (one long and one short shift) on the morning shift, two caregivers (one long and one short shift) on the afternoon shift and one caregiver on the night shift.</p> <p>In the dementia unit (Cressy) there are 20 of 20 dementia residents in total. There is one charge nurse/RN on duty in the morning and night shifts. The RNs from the hospital unit cover the afternoon shift. They are supported by three caregivers (two long and one short shift) on the morning shift, three caregivers (two long and one short shift) on the afternoon shift and one caregiver on the night shift.</p> <p>In the serviced apartments there are 15 of 47 rest home level residents. There is one charge nurse/RN on duty in the morning and afternoon shifts (until 10.00 pm). They are supported by four caregivers (one long and three short shifts) on the morning shift, three caregivers (one long and two short shifts) on the afternoon shift and one caregiver on the night shift.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses, enrolled nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Annual education around safe medication administration has been provided. Registered nurses complete syringe driver training. All medications are stored safely in each unit. Monthly delivery of medication blister packs is checked against the electronic medication charts and signed as checked in on the medication system. The medication fridges are checked daily. All eye drops and ointments were dated on opening. There was one hospital resident self-medicating with a self-medication assessment that had been reviewed three monthly by the GP. Medications are stored safely in the resident room. Eyedrops had been dated on opening. Expiry dates of impress and stock medications are checked monthly. Standing orders are used for the home GP only.</p> <p>Twelve medication charts (four rest home, four dementia care and four hospital) reviewed had photo identification, allergy status and had been reviewed by the GP at least three monthly. Signing sheets corresponded with the medication charts. Prescribing met legislative requirements and all 'as required' medication had an indication for use.</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>All meals are prepared and cooked on-site by qualified chefs, catering assistants and kitchenhands. Food services staff have attended food safety training. The Arvida dietitian reviewed the seasonal menu June 2018. The food control plan was submitted 25 June 2018 and awaiting verification. Dietary preferences and special diets are met including vegetarian. The service is trialling the use of purchased pureed foods. Resident dislikes are known and accommodated. The cook receives a resident dietary profile for new and respite care residents and is notified of any dietary changes including weight loss. Meals are transported to the rest home dining room in a bain marie. Meals are transported (in bain marie dishes) to the hospital unit in a dumb waiter from the kitchen. The meals are then served from a pre-heated bain marie. Nutritious snacks are available 24 hours in the dementia unit.</p> <p>A daily food control plan checklist is completed. Records were sighted for fridge and freezer temperatures, dishwasher temperatures, end-cooked foods and reheating of food. Perishable foods sighted in all the facility the fridges were dated. All dry goods were labelled with expiry dates. The dishwasher is serviced monthly by the chemical supplier. A cleaning schedule is maintained.</p> <p>Resident meetings and surveys along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family member interviewed were satisfied with the meals and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.5: Planning</p>	<p>FA</p>	<p>Resident care plans reviewed on the electronic system were resident focused and individualised. Support needs as assessed were included in the long-term care plans and reflected the outcomes of the interRAI assessments,</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>including falls prevention for at risk residents, risks of restraint use and pressure injury prevention interventions. The previous finding around care plans reflecting the resident current health status has been addressed. 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. Resident files demonstrated service integration.</p> <p>The two dementia care resident files reviewed had 24-hour leisure plan with documented behaviours, triggers and activities to distract and de-escalate behaviours. The long-term care included a behaviour management plan.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian and community mental health team.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP, nurse specialist consultation. There is documented evidence in the electronic system that 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.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessment, treatment and evaluations were sighted on the electronic system for seven of nine residents with wounds (three skin tears, one chronic ulcer, one surgical wound and two pressure injuries). Both pressure injuries of hospital residents were facility acquired (one unstageable and one stage two). The wound nurse specialist, district nurse and dietitian had been involved in the management of the unstageable pressure injury.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Electronic care plans and work logs are updated to meet the resident needs. Monitoring occurs for weight, blood pressure, blood sugar levels, pain, neurological observations, food and fluid charts, behaviour charts and re-positioning. 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</p>	<p>CI</p>	<p>There is a team of diversional therapists (DT) and a Wellness Leader who coordinate and implement activity programme for each area. The rest home and hospital have a Monday to Friday programme and the dementia care unit is Monday to Sunday. Each unit has a programme; however, many activities are integrated with activities taking place both in the upstairs hospital lounge/dining room and downstairs in the rest home lounge/dining room or community lounge. Residents are assisted to attend activities they choose to participate in. The rest home residents in studio apartments are invited to studio apartment and rest home activities. The activities offered in the studio apartments to all residents now includes "Exercise Alley". The service has maintained a continuous</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>improvement rating.</p> <p>The rest home and hospital programmes offer choice and variety of activities including, crafts, board games, quizzes, cooking club, knitting club, ladies coffee club, skittles. bowls, movies, music for pleasure, walking group and exercises. One-on-one time is spent with residents who do not wish to participate in group activities. There are volunteers, guest speakers, entertainers, church visitors, library and canine therapy involved in the activity programme. Cultural events and theme days are celebrated.</p> <p>Residents are encouraged to attend community groups and events. There is a van for outings/drives/shopping and a mobility van is hired for hospital level residents.</p> <p>Two DTs cover a seven-day week programme in the dementia unit from 9.30 am to 5.00 pm. There is flexibility in the programme to meet the residents needs and include meaningful activities, van rides, entertainment and walks. On the day of audit there were activities observed in each of the units including a canine therapy visit.</p> <p>A resident profile is completed on admission. Individual activity plans are reviewed six monthly as part of the MDT case conference review.</p> <p>The service receives feedback and suggestions for the programme through two monthly resident meetings and surveys.</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 initial care plans for long-term residents reviewed were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the multidisciplinary team case conference meeting that includes the RN, care staff, DT and resident/relative who is invited to attend. Evaluations identified if the resident/relative desired goals had been met or unmet.</p> <p>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.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 1 September 2018. There is a reactive and planned maintenance. The rest home nurses station has been relocated, leaving space to set up another (small) lounge area. The bedroom doors in the dementia care unit have been brightly painted in colours of the resident choice.</p>

for their purpose.		
<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 on-line infection control register. This data is monitored and evaluated monthly for trends and opportunities for improvements. Analysis of infections and corrective actions are discussed at the infection control committee meetings. Benchmarking occurs within the Arvida group. There has been one outbreak contained to the studio apartments in May 2017. Public health was notified, and case logs were completed as sighted.</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 policies and procedures to ensure that restraint is a last resort. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. At the time of the audit, there were five residents with six restraints (two lap belts and four bed rails) and one resident using an enabler (lap belt). The file for the resident with an enabler evidenced the enabler use is voluntary. Staff received training on restraint minimisation in August 2017.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

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>In November 2016, the service identified through meetings that studio and rest home residents (including those in studio apartments) were not enjoying the exercise programme in the lounge.</p> <p>There are now 15 rest home residents in studios. The studio apartment DT has developed and implemented an exercise programme</p>	<p>The studio apartment DT and the physiotherapist developed the exercises to increase stimulation, promote wellness, and reduce falls. The exercises are held in the downstairs widened area of the corridor, which also has seating for rest breaks. The corridor has an Exercise Ally street sign post. There are two organized sessions per week taken by the DT or care staff. Dining chairs are placed along the rail of the corridor for participants. Residents take their seats for chair exercises and use the rail to assist them in standing exercises. Music is played and the DT voices instructions. A video of residents participating in Exercise Ally exercises was viewed, which evidenced that 50% of the participants were rest home residents from the studio apartment and rest home unit. There are painted exercise instructions on the wall of Exercise Ally and the aim under the household model is to encourage residents to do ad hoc exercises at any time. A mini survey completed March 2018 evidenced good participation and enjoyment. Residents commented they feel their strength and balance has improved with one example being they are able to get out of their lounge chairs more easily.</p>

		that is incorporated into the Arvida Wellness module. Feedback from residents participating in the Exercise Ally programme evidenced greater participation and enjoyment of the exercise programme.	
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End of the report.