

Ashwood Park Lifecare (2012) Limited - Ashwood Park Retirement Village

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:	Ashwood Park Lifecare (2012) Limited
Premises audited:	Ashwood Park Retirement Village
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 3 December 2018 End date: 4 December 2018
Proposed changes to current services (if any):	The service has been verified as suitable to provide medical services under their current hospital certification.

Total beds occupied across all premises included in the audit on the first day of the audit: 115

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

Arvida Ashwood Park Lifecare is part of the Arvida aged care residential group. The rest home provides rest home, hospital and dementia level of care for up to 121 residents in the care centre and up to 35 residents at rest home level in the serviced apartments. On the day of the audit there were 115 residents. The service is operated by two managers with eleven years aged care experience. They are supported by an experienced facility clinical manager, quality manager and national quality manager. There is a stable workforce. The residents, relatives and allied health professionals interviewed spoke positively about the care and services provided at Ashwood Park.

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

The service has been awarded a continuous improvement rating around good practice and 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.		All standards applicable to this service fully attained with some standards exceeded.
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Staff at Ashwood Park 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. 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.

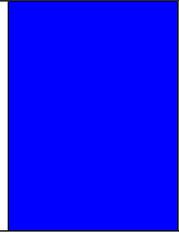
Organisational management

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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Ashwood Park 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 bi-monthly staff and quality improvement meetings. There is an annual internal audit calendar schedule. Residents and relatives are provided the opportunity to feedback on service delivery issues at bi-monthly resident meetings and via annual satisfaction surveys. 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 plan for 2018 is being completed as per schedule. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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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. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in electronic resident records 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. The registered nurses and senior caregivers responsible for administration of medicines complete annual education and medication competencies. The medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The activity team provide and implement an interesting and varied activity programme for each level of care. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

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. There are nutritional snacks available 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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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. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. There is a mix of bedrooms that have ensuites and communal use of toilets/showers. Rooms are personalised. 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. There is a staff member on duty at all times with 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.		Standards applicable to this service fully attained.
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Ashwood Park Lifecare has restraint minimisation and safe practice policies and procedures in place. At the time of the audit, the service had eight residents using eleven restraints and seven residents using enablers. A clinical manager 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. Staff receive training around restraint minimisation and enablers.

Infection prevention and control

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

Standards applicable to this service fully attained.

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. There have been no outbreaks.

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	48	0	0	0	0	0
Criteria	2	99	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 1.1.1: 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 twelve care staff (six HCAs, three clinical managers, one registered nurse (RN) and two diversional therapists) confirm their familiarity with the Code. Interviews with nine residents (six rest home and three hospital) and six families (two hospital and four dementia care) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality improvement meetings. Staff have received training on the Code, last occurring in November 2018.</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 consent.</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Written general consent forms were evident on all resident files reviewed (four hospital including one younger person and one respite care, four rest home including one younger person and one resident in serviced apartments and three dementia care). Specific consent had been signed by resident/relatives for procedures such as the influenza vaccine. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care.</p> <p>Enduring power of attorney (EPOA) evidence is filed in the residents' electronic charts. The EPOAs</p>

		<p>had been activated in the three dementia care resident files reviewed.</p> <p>Advance directives for healthcare had been completed where residents were deemed to be competent. Where residents were deemed incompetent to make a resuscitation decision, the GP had made a medically indicated resuscitation decision. There was documented evidence of discussion with the family. Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives.</p>
<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 have received training on advocacy. 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. There has been a focus on inter-generational partnerships with community agencies which have included visiting pre-school and schoolchildren. On interview, staff stated that residents are encouraged to build and maintain relationships. Residents and relatives interviewed confirmed that relative/family visiting could occur at any time.</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 service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. Ten complaints (eight in 2018 year to date and two in 2017) have been received at Ashwood Park 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>A complaint made through the Health & Disability Commissioner (HDC) in May 2017 has been investigated with a corrective action plan implemented and signed off. There was no further action required as confirmed in an HDC letter dated 25 June 2018.</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, facility nurse 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>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy 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.</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 was one resident (dementia care) that identified as Māori at the time of the audit. The file of the resident identified as Māori was reviewed and included a specific Māori 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 HCAs 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.</p>
<p>Standard 1.1.7: Discrimination</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</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>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>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. 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. Arvida is operationalising their vision 'to transform the ageing experience' within the care communities through the introduction of the wellness/household model. A dance exercise video was developed by the rest home clinical manager following research into dance and was found to delay the onset of dementia.</p> <p>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. Ashwood Park Lifecare introduced the wellness/household model in September 2018. 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.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>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. Fifteen incident/accidents (eight hospital, three rest home and four dementia level of care) forms reviewed for October 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. Interpreter services are available as required.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and</p>	<p>FA</p>	<p>Ashwood Park Lifecare is part of the Arvida Group. The service provides hospital, rest home and dementia level care for up to 121 residents and rest home level care for up to a further 35 residents in serviced apartments. On the day of the audit, there were 115 residents in total (40 hospital level residents, including 2 residents on respite care and 2 on younger persons with disabilities' (YPD)</p>

<p>appropriate to the needs of consumers.</p>		<p>contracts; 44 rest home residents, including 2 on YPD contracts; and 9 rest home residents in the 35 serviced apartments. There were 22 residents in the 26-bed dementia unit. All other residents were admitted under the aged residential related care (ARRC) agreement.</p> <p>There are two village managers (husband and wife). One village manager looks after the operational and financial management and the other village manager covers the HR management, property and maintenance requirements. The village managers have previously managed aged care facilities for 11 years and owned Ashwood Park Lifecare prior to the purchase by the Arvida Group in 2014. The village managers are supported by a facility nurse manager. The facility nurse manager has been at the service for three years. She is supported by a unit clinical manager in each of the three units (hospital, rest home and dementia care), all of who are qualified and experienced for the roles. There are two-unit clinical managers in the dementia unit who job share. Additionally, the management team includes a quality manager who is also the education coordinator.</p> <p>The village managers' report to the Arvida senior management team 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. Ashwood Park Lifecare has a business plan 2018/2019 and a quality and risk management programme.</p> <p>The village managers and facility nurse manager have completed in excess of eight hours of professional development in the past twelve 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 efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the village managers, the facility nurse manager or quality manager are in charge. Support is provided by the clinical managers and the care staff.</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</p>	<p>FA</p>	<p>There is a quality and risk management system in place at Ashwood Park Lifecare which is designed to monitor contractual and standards compliance. There is a 2018/2019 business/strategic plan that includes quality goals and risk management plans for Ashwood. The quality and risk management system support improved resident outcomes and identifies where improvement is needed. One of the village managers is responsible for providing oversight of the quality and risk management system on-site, which is also monitored at an organisational level. Interviews with staff confirmed that there is discussion about quality data at various facility meetings. Arvida Group policies are reviewed at least</p>

<p>continuous quality improvement principles.</p>		<p>every two years across the group. Head office sends out new/updated policies for staff to read. The service policies and processes meet relevant standards including those required to meet residents' medical needs.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. All staff interviewed could describe the quality programme corrective action process. Restraint and enabler use (when used) is reported within the bi-monthly quality improvement and clinical/RN meetings. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. A resident/relative satisfaction survey was completed in March 2018. Corrective actions have been established in areas where improvements were identified (eg, food/meals and activities). Resident/family meetings occur bi-monthly and the results of the satisfaction survey have been discussed at the meeting.</p> <p>The service has a health and safety management system that is regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the Health and Safety Committee. The quality manager is the health and safety officer and has completed specific health and safety training in her role. Hazard identification forms and an up-to-date hazard register is in place which was last reviewed in August 2018. Falls prevention strategies are implemented including identifying residents at higher risk of falling 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 facility nurse manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at bi-monthly staff meetings including actions to minimise recurrence. An RN conducts clinical follow up of residents. Fifteen incident forms reviewed demonstrated that appropriate clinical follow up and investigation occurred following incidents. Neurological observation forms were documented and completed for four reviewed unwitnessed falls or potential head injuries.</p> <p>Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been 12 section 31 incident notifications required since the last audit. There were three notifications for police investigations (one missing resident in November 2018 and two resident behaviours in August and May 2018). Eight pressure injuries (two stage IV in April and May 2018, one stage III in October 2018 and five unstageable pressure injuries (two in September and three in November 2018) and one health and safety risk (bits of plastic found in a pureed food) in September 2018.</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 require that relevant checks are completed to validate the individual's qualifications, experience and veracity. Twelve staff files were reviewed (one facility nurse manager, three clinical managers, two RNs, five HCAs and one diversional therapist). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in ten staff files reviewed with the other two staff 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. The orientation programme includes video and e-learning on all aspects of the facilities procedures. Completed orientation is on files and staff described the orientation programme.</p> <p>The in-service education programme for 2018 year to date is being completed. Arvida has introduced an online training programme for staff. Discussions with the HCAs and RNs confirmed that online training through Altura is available. Eight hours of staff development or in-service education has been provided annually. There are 12 RNs and 9 have completed interRAI training. Registered nurses have appropriate training and competencies to meet the medical needs of residents, including palliative care. There are 16 HCAs who work routinely in the dementia unit and 12 have completed the dementia standards. Four HCAs are in the process of completing and have all commenced work within the last 18 months. The Arvida group hosts two conferences per year for village managers and clinical managers to promote the updating of skills and knowledge.</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>Ashwood Park Lifecare's 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 131 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village managers and facility nurse manager work 40 hours per week, Monday to Friday and are available on-call after hours. In addition, there are three-unit clinical managers (hospital, rest home and dementia care). There is at least one RN on at any one time. Interviews with staff, residents and family members confirm there are sufficient staff to meet the needs of residents.</p> <p>The service currently has 115 residents in total. 40 of 48 hospital residents, 44 of 47 rest home residents, 22 of 26 dementia care residents and 9 rest home residents across the 35 certified serviced apartments.</p> <p>In the hospital unit, there are 40 hospital and 3 rest home residents. The hospital clinical manager is supported by two RNs on the morning and afternoon shifts and one RN on night duty. There are eight HCAs rostered on the morning, seven HCAs on the afternoon shift and three HCAs on night duty.</p> <p>In the rest home unit, there are 41 rest home residents. The rest home clinical manager is supported one RN on the morning and afternoon shifts. There are five HCAs rostered on the morning, four HCAs</p>

		<p>on the afternoon shift and two HCAs on night duty. The hospital RN covers the rest home unit on the night shift.</p> <p>In the dementia care unit there are 22 residents. The dementia clinical manager is supported by four HCAs rostered on the morning shift, three on the afternoon shift and one HCA on night duty. The hospital RNs cover the dementia unit on the afternoon and night shifts.</p> <p>In the serviced apartments, there are nine rest home residents and there is a separate roster with two HCAs on the morning shift and one HCA on the afternoon shift. The HCA in the rest home supervises the rest home level care residents in the serviced apartments on the night shift.</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>	FA	<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 and dated by the relevant HCA or RN. Electronic records are integrated and include input from GPs and allied health.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services including rest home, hospital and dementia level of care are provided for families and residents prior to admission or on entry to the service. Two files of younger persons included an assessment confirming the appropriate level of care and a needs assessment approval. All admission agreements reviewed (for long-term residents) align with all contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were 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 were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p>	FA	<p>There are policies and procedures in place for safe medicine management. Clinical staff who administer medications (RNs, enrolled nurses and senior caregivers) have been assessed for</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>competency on an annual basis and attend annual medication education. Registered nurses have completed syringe driver training. Medications are stored safely in each unit. All medication (blister packs) are checked on delivery against the medication chart with documented evidence on the electronic medication charts. The medication fridges are checked daily and are maintained within the acceptable temperature range. All eye drops sighted in the medication trolleys were dated on opening. There is a bulk supply order for hospital level residents. There were two rest home residents and one hospital resident self-medicating on the day of audit. Self-medication competencies had been completed on eCase and reviewed three-monthly.</p> <p>Twenty-two medication charts reviewed met prescribing requirements. The medication charts had been reviewed three-monthly.</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>The meals and baking are prepared and cooked on-site by a contracted service. The head chef is supported by a weekend cook and catering assistants. Food services staff have completed orientation on recruitment and ongoing training. There is a four-weekly spring/summer menu in place that has been reviewed by the dietitian. The menu provides a vegetarian option and pureed/soft meals. The chef receives resident dietary profiles and notified of any dietary changes. Smoothies, complan and fortified foods are provided for any residents identified with weight loss. Resident dislikes/allergies are accommodated, and alternative foods offered. There are additional foods and nutritious snacks provided for residents in the dementia care unit. Meals are delivered in a hot box to the hospital, serviced apartments and dementia dining rooms. The kitchen is adjacent to the rest home dining room for the serving of meals. The HCAs serve continental breakfasts to residents in rooms.</p> <p>Freezer, fridge and end cooked, re-heating (as required) and serving temperatures are taken and recorded twice daily. The dishwasher rinse and wash temperatures are taken and recorded. All perishable foods and dry goods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. The current food control plan has been verified and expires 16 May 2019.</p> <p>Residents can provide feedback on the meals through resident meetings and resident survey. The head chef attends resident meetings. Residents and relatives interviewed spoke positively about the choices and meals provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service</p>	<p>FA</p>	<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>is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RN completes an interim care plan on admission including relevant risk assessment tools. Risk assessments are completely six-monthly or earlier due to health changes. InterRAI assessments and long-term care plans were completed within the required timeframes for long-term residents including the younger persons. An interim assessment and care plan had been completed for the one resident for respite care. The outcomes of assessments are reflected in the needs and supports documented in the care plans. Other available information such as discharge summaries, medical notes and consultation with resident/relative or significant others are included in the long-term care plans.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Resident care plans reviewed on the resident electronic system for long-term residents were resident-focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. The eCase programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Care plans for the younger persons included the involvement of allied health and community workers to assist the residents in meeting their specific goals around wellbeing. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to): current infection, wound or recent fall. Any short-term changes are made to the electronic care plan using the fast edit option. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian and community mental health services.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Care plans reflect the required health monitoring interventions for individual residents. Computers in each nurse's station allows caregivers the opportunity to sign a task has been completed (eg, resident turns, bowel chart, behaviour chart restraint monitoring). Monitoring charts are well utilised. Electronic care plans are updated for changes to health. Resident falls are reported electronically and recorded in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family are notified of all changes to health as evidenced in the electronic progress notes.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. There is access to a</p>

		<p>continence specialist as required.</p> <p>Wound assessments. wound management plans and photos were reviewed on eCase for 14 residents (skin tears, abrasions and pressure injuries). There were four hospital level residents and two rest home residents with pressure injuries on the day of audit (one stage I, one stage II (on admission), two stage II and two healing stage III). When wounds are due for a change of dressing, a task is automated on the RN daily schedule. The district wound nurse has been involved in the management of complex or non-healing wounds. Caregivers document changes of position on eCase.</p> <p>Monitoring charts are completed on the electronic system, such as: pain; observations; behaviour; weight; food and fluids; neurological observations; and re-positioning. Worklogs for the caregivers and RNs record cares and monitoring is completed as outlined in the care plans.</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 five diversional therapists (DT) to coordinate and implement the Monday to Friday activity programme in the studio apartment, rest home and hospital unit. The DT in the dementia care unit works a 'four on, four off' roster and the HCAs coordinate and implement activities in the dementia unit as part of their role. A volunteer DT is involved in assisting with activities and facilitates the men's group in the rest home/hospital and the dementia care unit. Each unit has a programme and there are some integrated activities including fortnightly church services, entertainment and men's club. The armchair travel club has proven popular with the rest home residents in the studios and rest home and meet weekly. Theme days and special occasions are celebrated. Residents are assisted to attend the activities. There are plenty of resources available for care staff to implement activities.</p> <p>The activity team provide individual and group activities that meets the cognitive and physical abilities and preferences of the residents. Activities include (but not limited to): exercise groups; dance exercises; newspaper reading; board games; crafts; baking; reminiscing; music; bowls; beauty time; happy hour; movies; gardening; and garden walks. One-on-one activities such as individual walks, newspaper reading, and hand massage occur for residents who choose not to be involved in group activities.</p> <p>Activities in the dementia unit are flexible, home-based (baking, folding washing, sweeping floors) and are meaningful to the residents. Activity suggestions for residents is displayed and resources are plentiful. Cooked breakfasts are provided in the dementia unit which generate conversations, socialisation and reminiscing for residents.</p> <p>The DT completes an individual under 65 years activity plan in consultation with the younger person that identifies their specific recreational preferences and community involvement. The younger persons choose to attend group activities and there is one-on-one time spent with them such as</p>

		<p>shopping or activities in their rooms.</p> <p>There are regular entertainers and community visitors including: churches; preschool children; school children for their reading programme; Red Cross volunteers for one-on-one visiting; and weekly pet therapy.</p> <p>There are weekly outings/scenic drives for all residents and shopping trips.</p> <p>A resident leisure profile is completed soon after admission. Individual leisure plans were seen in resident electronic files. The activity coordinators are involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through resident integrated meetings (rest home and hospital), family meetings in the dementia care unit and annual surveys. The residents and relatives interviewed were happy with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All interim 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 RN six-monthly or earlier for any health changes for the long-term resident files reviewed. Family are invited to attend the multidisciplinary review meeting and case conference notes are kept. Written evaluations reviewed identified if the resident goals had been met or unmet. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>There are documented policies and procedures in relation to exit, transfer or transition of residents. Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas in each unit. Cleaning chemicals are dispensed through a pre-mixing unit in locked cleaners' rooms. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for</p>

<p>as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>containers. Gloves, goggles and aprons are available for staff and they were observed to be wearing these as they carried out their duties on the day of audit. There are sluice rooms in each unit (one with a sanitizer) with appropriate personal protective clothing. A chemical spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 1 July 2019. The building is two levels with 14 of 35 serviced apartments upstairs with lift and stair access. The remaining serviced apartments, rest home, hospital and dementia care units are on the ground floor. There is a maintenance person who works full-time and is supported by the village managers. The maintenance person is on the Health and Safety Committee and holds a site safety certificate. There is a maintenance request book in each nurse's station which is checked daily for repair and maintenance requests. There is a planned maintenance schedule that includes electrical testing and tagging, and resident equipment checks and calibrations such as wheelchairs, hoists, weigh scales and electric beds. Monthly hot water tests are completed for resident areas and are below 45 degrees Celsius. The maintenance person and the village managers share the on-call for facility concerns. Essential contractors are available 24 hours as required.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. There is one outdoor area for a resident who smokes. All other areas are smoke-free.</p> <p>The dementia unit garden is safely fenced. Doors from the dining and lounge areas open out onto the gardens with a walking pathway.</p> <p>Healthcare assistants interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene</p>	<p>FA</p>	<p>All serviced apartments have full ensuites. There is a mix of ensuited resident rooms and communal bathrooms/showers in the rest home, hospital and dementia care units. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is sufficient space in toilet and shower areas to accommodate shower chairs if appropriate. There are signs and privacy locks on all shower/toilet doors.</p>

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	All rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<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 are large and small communal areas in the rest home, hospital and dementia unit. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There are spacious dining rooms and lounges in each unit. The dementia unit has an alternative dining/activity area.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	All laundry and cleaning are done by dedicated housekeeping staff seven days a week. There is a laundry and cleaning manual and safety data sheets available. The laundry is divided into a “dirty” and “clean” area with two doors (entry and exit). There is a separate clean laundry folding and ironing room. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system and the chemical provider, who also monitors the effectiveness of chemicals and the laundry/cleaning processes. The cleaner’s trolley was attended at all times or locked away when not in use. All chemicals on the cleaner’s trolley were labelled.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency/disaster management plan 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 24 October 2018. All RNs hold a current first aid certificate. There is an approved NZ Fire Service evacuation scheme in place, letter dated 22 August 1994. A contracted service provides checking of all facility equipment including fire equipment. Fire 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 for up to four hours.</p> <p>The facility is well prepared for civil emergencies with civil defence and spill kits and a store of</p>

		<p>emergency water (water tank and bottled water) and one BBQ and gas hobs in the kitchen for alternative cooking. The service has a generator on-site. 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>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation with some resident rooms and communal rooms opening out onto the internal courtyards. There is underfloor heating and ceiling panels throughout the facility.</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>	FA	<p>The clinical nurse manager is the infection control coordinator with responsibility of overseeing infection control management for the facility. The infection control coordinator provides a monthly report to the quality meeting and bi-monthly report to head office. The infection control programme is reviewed annually in consultation with the Infection Control Committee. The last review was February 2018.</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitizers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has completed the MOH infection prevention and control online course in July 2018. The infection control committee comprise of three representatives including a rest home RN, dementia care RN and dementia care clinical manager. There are signed job descriptions for the infection control coordinator and committee members. The committee meet three-monthly and the meeting minutes are available in the staff room which staff read and sign. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. Advice and support are readily available from expertise within the organisation, infection control nurse specialist at the DHB, laboratory technician, nurse practitioner and GPs.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes responsibilities of the infection control team and training and education of staff. The policies have been reviewed by the Arvida Group at head office.</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 on orientation and annually that includes infection control induction, hand hygiene audits and infection control competencies. Resident education occurs as part of daily cares.</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 signs, symptoms and definition of infection. Infections are entered into the infection register on the electronic database. Surveillance of all infections is entered onto a monthly infection summary. The service receives a monthly antibiotic use form from the pharmacy. This data is monitored and analysed for trends monthly and annually. Infection control surveillance is discussed at facility meetings and meeting minutes are displayed for staff. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives benchmarking feedback from head office. There have been no outbreaks.</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. At the time of the audit, there were eight residents with eleven restraints, and seven residents using enablers. Enabler use is voluntary. All necessary assessments and evaluations had been completed in relation to the restraints. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint has been discussed as part of quality</p>

		improvement meetings. Staff receive training around restraint minimisation and enablers.
<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	The hospital clinical manager is the designated restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, RNs, resident/or representative and medical practitioner.
<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	The service completes assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the three restraint and two enabler resident files reviewed, assessments and consents were completed.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. An assessment form/process is completed for all restraints and enablers. The three restraint and two enabler resident files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms included regular two-hourly monitoring. The service has a restraint and enablers register, which was up to date.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are completed by the restraint coordinator at least three-monthly or earlier if required. A review of three restraint and two enabler resident files identified that evaluations are up to date.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p>	FA	Individual approved restraint is reviewed at least three-monthly as part of the medical review with the resident/family/whānau, as appropriate. Restraint usage is monitored regularly by the restraint coordinator. Corrective actions are monitored. Restraint is discussed at the quality improvement

Services demonstrate the monitoring and quality review of their use of restraint.		meetings. Individual restraint use is monitored and recorded by staff.
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Specific results for criterion where corrective actions are required

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

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

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

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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>It was observed that some residents in the rest home were not socialising due to cognitive deficits limiting their self-motivation in exercise or activity. There were also behaviours that challenged within the group of residents.</p>	<p>Since the surveillance audit, the rest home clinical manager has been studying research around the effects of “tapping” and dance on the reduction of challenging behaviours when sessions were offered for 20-30 minutes a day. A site-specific dance video was created by staff for residents. There had been increasing resident attendance at the daily dance exercises and the sessions were open to all rest home residents (including serviced apartments). During the last six months of dance exercises, a downward trend in challenging behaviours was noted with zero in recent months, for the rest home residents identified with cognitive deficits. It was further identified that an exercise video be developed focused on improving mobility, strength and balance as part of the DHB falls prevention programme. The rest home clinical manager, in conjunction with the community ACC physiotherapist and residents, developed the second video which gives step by step instructions for residents to follow. The interaction with residents and their families has been successful and there are recorded videos of relative interviews and feedback on their relatives physical and emotional improvement and wellbeing. The facility contracted physio is consulted prior to residents attending such as respite post-surgical or residents with limited mobility. An example of physical improvement for one resident was viewed on video from limited shoulder movement to free shoulder movement over a period of three months. The service entered the DHB Health Innovation award in November 2018 and won the award evidencing the success of</p>

			this innovative project and the positive impact on the lives of residents.
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The diversional therapy staff meet with residents regularly to discuss feedback on the programme and discuss other activities and suggestions for the programme. The rest home and serviced apartment residents suggested visiting other countries from their armchairs, so they could feel included in the outside world and other adventures.</p>	<p>The Armchair Travel Club started as an informal gathering to discuss countries the residents would like to travel and how this was going to be achieved from their armchairs. The residents visited the airport to obtain their passports. A large picture of an aeroplane with residents faces in the windows is posted on a large wall in the rest home/serviced apartment area. This has encouraged more residents to join the armchair travel club (up to 20 residents) which meet weekly and has extended from a short journey to an around the world trip. Every two weeks the group stop at a country and spend time learning/sharing information about that country. Residents and families are encouraged to share souvenirs and artefacts from their own travels. At each stop the country national flower, cultural identify and flags are displayed. Authentic foods are sourced and shared. Examples are when the group stopped at Switzerland and as well as learning about the country and sampling authentic foods, a St Bernard dog and lace makers visited; and when the group stopped at Egypt, a resident's family visited dressed in the national costume. A survey of the armchair travel group in September 2018 returned 15 very positive responses with the group now planning a three-month cruise. A slide show was entered into the NZDT conference which won first place.</p>

End of the report.