

Adriel Rest Home Limited - Adriel Resthome

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

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

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

The specifics of this audit included:

Legal entity: Adriel Rest Home Limited

Premises audited: Adriel Resthome

Services audited: Dementia care

Dates of audit: Start date: 24 January 2019 End date: 24 January 2019

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: 34

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

Adriel Rest Home, which operates in two linked buildings as Adriel Rest Home Ltd., provides dementia rest home level care for up to 42 residents. The service is operated by the longstanding owner who is the registered nurse and managed day to day by a facility manager. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of relevant policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, support partners and a general practitioner from the local practice.

This audit has identified areas requiring improvements relating to human resources management, evaluation, medication management and development of a food safety plan. Improvements have been made to kitchen management and review of the menu and the use of double rooms.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained with the few complaints received resolved promptly and effectively in accordance with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Business and quality and risk management plans have recently been updated and include clear direction, goals, values and the mission statement of the organisation. Monitoring of the services is undertaken, with analysis of results and discussion at the monthly quality meetings. An experienced and suitably qualified person manages the facility with on-site support and engagement from the owner.

The quality and risk management systems include the collection and analysis of quality improvement data, identifies any trends and leads to improvements. Staff are involved through regular feedback at staff meetings. Resident/family and staff surveys are undertaken. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. A suite of current policies and procedures support service delivery.

Processes for the appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual staff performance review. Staffing levels and skill mix meet the changing needs of residents.

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>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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A registered nurse is on site Monday to Friday and is supported by support partners and the local medical centre and pharmacist. The registered nurse/owner and the manager share on-call 24 hours per day with the registered nurse responding to clinical issues.

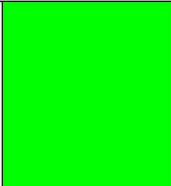
Service delivery plans are based on the interRAI assessment and admission information; they are individualised and are appropriate to guide the care of the residents. Short term care plans accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed on a regular basis. Evaluation occurs as part of the interRAI re-assessment. Progress notes and shift handover guide continuity of care. Family members informed they are involved in the care planning of their relative and residents interviewed reported an overall satisfaction with the services. The GP interviewed stated the level of care was of a high standard.

The planned activity programme, overseen by four diversional therapists, provides residents with a variety of individual and group activities and significant interaction with the local community.

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

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed.

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 is a current Building Warrant of Fitness displayed.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers or restraints in use at the time of the surveillance. The Spark of Life philosophy and approach underpin the management of challenging behaviours and staff undertake appropriate ongoing training. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme is led by an experienced and trained infection control coordinator. This programme is reviewed annually. Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	2	2	0	0
Criteria	0	35	0	2	3	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 complaints form used meets the requirements of Right 10 of the Code and is available in both areas of the facility. Information on the complaint process is provided to residents and families on admission in the entry pack. Family members spoken to knew how they could complain. There were also a number of documented compliments in relation to care recorded in the staff meeting minutes and quality meeting minutes.</p> <p>The facility manager is responsible for complaints management and follow up. Review of the complaints register indicated three complaints have been received over the past year and suitable actions taken. A record of progress towards a resolution was fully documented and all resolved within the required timeframe. Improvements had been initiated where this was indicated. The staff spoken to have a good understanding of the complaint process and the actions they needed to take. No external complaints have been received since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Family members confirmed they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and are invited to GP visits. If unable to attend they are advised of the outcomes. This was supported in residents' records reviewed. Staff were clear about the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this has never been required. A person from</p>

<p>provide an environment conducive to effective communication.</p>		<p>another ethnicity is able to speak sufficient English to understand and to be understood. Family assist with any uncertainty. Staff were observed to be patient with the residents in this service and to use a range of strategies to improve the chance the resident(s) would understand them. Aspects of the Spark of Life philosophy are enhancing the communication processes with these residents. According to family members the communication processes used at Adriel are reducing their relative's frustrations.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The organisation has an established vision/mission/values document which is displayed in key areas. It is updated annually to reflect changes in the organisation's priorities. Adriel Rest Home aims to be recognised as an innovative leader in the care of people experiencing dementia. There is an eight-point strategic plan which has recently been updated for the 2019 year. Review of the strategic plan indicates clear priorities which include an increase in family/whānau and consumer participation, completion of building improvement, specific staff training development and support, particularly in relation to the "Spark of life" programme and other quality improvement strategies.</p> <p>The service is managed by a facility manager who is experienced in service management and has been in the role for more than five years. She has responsibility for the day-to-day operation. She shares call with the owner/registered nurse to ensure support is available to staff throughout the 24-hour period. The owner is experienced in the sector and has owned the facility for more than 16 years.</p> <p>The service holds contracts with Canterbury District Health Board (CDHB) for rest home dementia care and respite care. Thirty-four dementia residents were receiving services under the contract at the time of audit. Completion of renovations in the near future will enable the facility to return to full occupancy.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. Incidents, complaints, ongoing audit activity in accordance with the audit schedule, annual resident/family/whānau surveys, health and safety, monitoring of infections, falls and other indicators as well as regular staff meetings and monthly quality meetings support the process.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and this information is reported and discussed at the monthly quality meetings and the regular staff meetings. Team leader meetings are now held weekly to discuss residents and their changing needs. Staff reported they received information about audits, staff injuries, incident and infection rates at the staff meetings. Examples of corrective action planning was evident as a result of trends and analysis from incident reporting. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent resident/family/whānau survey had a response rate of approximately one third of current residents/families. There were several useful comments which have been integrated into the day-to-day care and the work undertaken</p>

		<p>by the team leaders such as increased attention and consistency for aspects of personal care. A staff survey has also been undertaken in 2018, with staff stating that they were made aware of the results.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and those reviewed at this audit were current and part of the document management system.</p> <p>The quality plan also includes reference to organisational risk and development of mitigation strategies. These are regularly reviewed and updated. Health and safety hazards are identified and managed.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. She is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Review of staff injuries is an agenda item at the quality and staff meeting.</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>	FA	<p>Staff document adverse and near miss events on an incident reporting form, and a medication error report. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at both the quality meeting and staff meeting.</p> <p>The facility manager described essential notification reporting requirements, including section 31 requirements. She advises there has been no notifications of significant events made to the external bodies, no issues-based audits or other notifications required since the previous certification audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	PA Moderate	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks and validation of qualifications. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained except for completion of police vetting since November 2017. The owner/RN's practising certificates (APC) is current.</p> <p>Staff orientation includes all necessary components relevant to the role. One staff member presently undertaking orientation stated the process is preparing them well for their role. Staff records reviewed show documentation of</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>completed orientation and a performance review after three-months and annually thereafter.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The mandatory training programme covers all key requirements including infection prevention and control, resident's rights, palliative care, health and safety, challenging behaviours and nutrition and hydration, in the 2019 plan. Regular training is a strength of the organisation. First Aid trained staff provide shift cover (see CAR 1.2.7.3).</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There is a qualified assessor available on-site for the programme. Adriel Rest Home also provides an introductory session for all new staff on the principles of the "Spark of Life" as part of its philosophy of care. Staff are also offered training as "Spark of Life" Practitioners from one of the two master practitioners available on-site (the manager and owner/registered nurse). All long-standing staff have completed relevant dementia care unit standards and new staff are commencing this following the introduction to the "Spark of Life" programme. The owner is a registered nurse and is competent to undertake interRAI assessments on site. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals in the sampled staff files.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents, occupancy and location of residents within the two areas of the facility. On occasion, staff will be reallocated to work in the other area, including on nightshift, when one staff member "floats" between the two homes.</p> <p>An afterhours on call roster is in place, with staff confirming that there is good telephone access to advice when needed from either the manager or owner/registered nurse. Support partners interviewed reported increasing acuity of residents over recent months, but that additional equipment has been provided to assist with mobility issues. Family/whānau interviewed confirmed sufficient staff are available to support residents.</p> <p>Observations and review of the three-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Staff interviewed confirmed they work as a team to ensure cover is not compromised by staying longer hours if needed and they seldom "work short". A staff member with a first aid certificate is identified on the roster for each shift, although there have been two gaps noted in the current week and further roster gaps to be filled during a period of high annual leave. (see CAR 1.2.7.3).</p>
<p>Standard 1.3.12: Medicine Management</p>	<p>PA Low</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using a paper-based and unit dose packaging system) was observed on</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. This was verified by review of staff records, observation and staff interviews. The registered nurse oversees training and competency requirements once a new staff member becomes confident with their role or following a medication incident.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. Not all medications sighted were within current use by dates or labelled with the resident's name. Clinical pharmacist input is provided when requested.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provides evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>A review of twelve medication charts identified good prescribing practices including the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines.</p> <p>There were no residents self-administering medications in this dementia facility.</p> <p>There is an implemented process for reporting and analysis of medication errors. Patterns of reported errors are primarily missed doses of non-packaged medication or incomplete administration records for which a corrective plan has been actioned.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The food service is provided on site by three key cooks. There are two kitchens, one in the Adriel Rest Home and one in Adriel House. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in April 2018, which addresses a previously raised corrective action. Recommendations made at that time have been implemented.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Copies of these, which detail personal food preferences, any special diets and modified texture requirements, are provided to the relevant kitchen and were sighted in folders. Kitchen staff described how these are accommodated in the daily meal plan. Residents in both units of the facility have access to food and fluids over 24 hours a day to meet their nutritional needs. Special equipment, to meet resident's nutritional needs, is available and residents requiring assistance with their meals were observed to be receiving this. There was no evidence of weight loss among residents, unless through a disease process, which was noted by the GP. Family members were satisfied</p>

		<p>with the meals provided and believed good food and plenty of it is provided. Residents interviewed all said the food was 'good', or 'okay'.</p> <p>Most food preparation is undertaken in one of the two kitchens the day prior to the cooking. One of the cooks completes most of the baking. A range of aspects of food procurement, production, preparation, storage, transportation, delivery and disposal were reviewed to ensure they are complying with expectations. There was no evidence of the issues regarding storage as raised for corrective action at the last audit. However, there was no food safety plan as required by current legislation and this has been raised for corrective action, which means this criterion remains as a corrective action, albeit the reasons are different. Temperatures, including for high risk items, are monitored appropriately and recorded, kitchen waste disposal is safe, and a kitchen cleaning schedule is being adhered to. All kitchen workers have completed relevant food safety and food handling training according to their role.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observation and interviews verified the provision of care to residents was consistent with their assessed needs, goals and documented plan of care. The residents' files showed evidence of discussion and involvement of family. Family interviewed reported the staff knew their relative well and had no concerns with the care provided.</p> <p>The attention to meeting the diverse range of each resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, medical orders are followed, and that care is of a high standard. Support partners confirmed that care was provided as outlined in the care plan. A range of equipment and resources was available suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is coordinated by four trained diversional therapists who hold a National Certificate in Diversional Therapy. The programme is available seven hours per day, seven days per week.</p> <p>A personal profile which includes a social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. The information obtained is reviewed to help formulate an activity programme that is meaningful to the residents. The residents' activity needs are evaluated on admission and an individual activities plan is formulated covering physical, emotional, sensory, intellectual, speech/communication, psychosocial, environmental and cultural activities. The level of each person's participation in the activities programme is monitored and evaluation of the personal activity goals occurs six-monthly.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events or outings are offered. Activities for residents are specific to the needs and abilities of the people living there with residents encouraged to participate in the day to day activity of the facility,</p>

		<p>examples include cooking activities and feeding the facility guinea pigs and chickens. Activities are offered at times when residents are most physically active and/or restless. The daytime programme offered by the diversional therapists is supported with evening activities offered by support partners who follow the individual activities plans and have access to appropriate equipment. Copies of the activities programme, and individual activities plans were sighted, and matched interests identified in the assessment data.</p> <p>Families/whānau are involved in evaluating and improving the programme through ongoing conversations with the manager and staff. All those interviewed reported that the staff are excellent at ensuring the residents have plenty to do, or be involved in, and noted how pleasant and stimulating the environment is. Residents interviewed confirmed they have plenty to do and go out to different places.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluation does not occur, however evaluation is incorporated into the interRAI re-assessment every six months and where progress is different from expected. Examples of long and short-term care plans being reviewed and updated were sighted; however not all plans indicate the resident's level of response to planned intervention and progress towards their documented goals.</p> <p>With such minimal evaluation, the severity of change in at least two residents' condition, was not adequately documented or followed through in the service delivery plan. Hence, referrals for reassessments has not occurred as would be expected. This was verified by observations made, family interview, file reviews and interview with the registered nurse.</p> <p>Activities plans are evaluated against the resident's goals six monthly and plans updated as the resident's assessed needs change.</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>A current building warrant of fitness (issued 3 April 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. A handyman is available for minor repairs. The testing and tagging of equipment and calibration of equipment is current and confirmed by inspection. Hot water temperatures are maintained within the recommended range.</p> <p>External areas are safely maintained and are appropriate to the resident group and setting. The extensive outdoor area is available for residents to enjoy and incorporated into daily activities. There is seating, shade, vegetable and flower gardens and animals accessible to residents.</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>	<p>FA</p>	<p>Surveillance of infections is a component of the documented infection control programme. The registered nurse/owner is the infection control coordinator and undertakes the surveillance of infections. Infections reviewed in the surveillance process are as per those recommended for long term care facilities and include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. All infections are initially recorded on an incidence of infection report form. New infections and any required management plan are discussed at shift handover, to ensure early intervention occurs and the local medical centre is involved from the time any infection is suspected.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Completed records of these were viewed. An infection control monthly reporting record form is completed and copies of these were also reviewed. A summary of the results is reported at the monthly quality meetings and at the monthly staff meetings and these were evident in the minutes of these meetings. An annual report that identifies trends for the past year provides comparisons with previous years and reviews the effectiveness of interventions is completed in February each year. This is reportedly underway, however, has not yet been completed as it is scheduled for February. Although no benchmarking process is in place, the documentation provided showed that infection rates are presenting as low and early intervention is occurring.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures, that were last reviewed in May 2018, meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers, should such interventions be required. A flow chart on the management of challenging behaviour demonstrates the Spark of Life philosophy. The restraint coordinator, who is also the registered nurse/owner, is suitably trained and provides support and oversight for enabler and restraint management in the facility. During interview, she demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, there were no residents using any form of restraint or an enabler. The restraint register showed that the last entry was for personal restraint when a staff person held a person's hands to enable them to be assisted with a shower. Relevant documentation was in the register. There were four other examples of single event personal restraint having been used since 2015.</p> <p>The restraint coordinator noted that the personal restraint was used only as a last resort when all alternatives had been explored, which was confirmed by staff. Staff have completed training on restraint use and behaviour management (17 November 2018) and those who did not attend the in-service were required to complete a questionnaire. During incidental staff interviews, those asked were familiar with the requirements and described a range of techniques used to help prevent any use of restraint. Results of an internal use of restraint/enabler compliance audit for 2018 was also viewed.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>Review of staff files for new appointments in the last year indicates that policing vetting has not been completed for the staff in accordance with policy. The manager reports that the person responsible for the process has left the organisation and there have been difficulties getting access to the website. This is still in process and no new staff have been police vetted since November 2017. No files reviewed for appointments made during this period include police vetting.</p> <p>First Aid training is offered to staff who are team leaders, diversional therapists, to some senior staff who work full shifts and the manager. These certificates are up to date. First aid trained staff are expected to provide first aid cover for the two homes on the site. The roster has been under pressure during the holiday period with high annual leave demand. There are roster gaps still to be filled on the three-week cycle and two shifts in the current week without first aid cover. First aid competent staff are clearly designated on the roster, but it is reported by staff and confirmed by the manager that some shifts are reliant on the off-site on call staff member to provide this cover.</p>	<p>The appointment of appropriate service providers to safely meet the needs of consumers cannot be assured.</p> <p>a) There has been no police vetting completed for (eight of eight) new staff appointed during from November 2017 to the present time.</p> <p>b) Inspection of the three-week roster cycle indicates that most shifts are covered with first aid competent</p>	<p>a) Act to complete police vetting for all staff employed since November 2017 and implement this on an ongoing basis.</p> <p>b) Ensure there are sufficient staff trained and competent in first aid to provide on-site cover for all rostered shifts.</p> <p>90 days</p>

			<p>staff member, however there is no on site first aid cover for two</p> <p>shifts and at least five other vacant shifts requiring a first aid competent staff member to cover annual leave in week one of the roster.</p>	
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>When interviewed, the registered nurse and medication competent support partner, could identify the correct procedure for labelling and storage of medication. At the time of audit, there were examples of out of date and unlabelled non-packaged medicines in both areas of the facility. Examples sighted included eye drop containers that had been open for six weeks and 10 months respectively and one ointment and one inhaler were not identifiable with a resident's name or prescription label. A review of medication charts identified two residents are prescribed this same inhaler medication and the correct resident could not be identified for this item. One unnamed 'over the counter' medication was found in use in the trolley and was not prescribed for a resident. This was a previous finding and has not been fully addressed.</p>	<p>Inspection of medications found; an 'over the counter' medicine in use that was not prescribed for a resident, an unnamed inhaler in the medication trolley, (with two residents prescribed this medication), an unnamed ointment and two expired eye drops noted to be in use.</p>	<p>Ensure that all medication is prescribed, managed and administered to comply with legislation, protocols and guidelines.</p> <p>180 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production,</p>	PA Low	<p>A range of food safety processes and checks are in place in both kitchens with daily temperatures of fridges and freezers being checked and recorded, the temperature of hot protein dishes, the daily signing off of the kitchen cleaning schedules, the correct storage and accountable processes of frozen, refrigerated food and dry goods and the kitchen staff have completed an update on food</p>	<p>There is not currently an approved Food Safety Plan available for this service, as required by legislation.</p>	<p>A Food Safety Plan that has been approved by a relevant authority is in operation and a copy of the registration on</p>

preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		<p>safety. A certificate of safety for kitchen waste being fed to pigs was sighted.</p> <p>However, although the registered nurse/owner was familiar with the requirements, there was no evidence available of a Food Plan having been registered with a relevant authority such as the local district council or the Ministry of Primary Industries.</p>		<p>display.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA</p> <p>Moderate</p>	<p>Evaluation occurs as part of the interRAI re-assessments, which are completed by the registered nurse/owner and were up to date. No other formal evaluation was documented, other than for activity plans. Of the evaluations sighted, not all were timely and comprehensive. In five of six files reviewed, the evaluation of both short and long-term care plans did not detail response to planned interventions or progress against identified goals. Three of four short term care plans sighted had not been evaluated. File review regarding evaluations was extended to include two further files, which confirmed the previous findings. Review of personal files and interview with the registered nurse confirmed no formal evaluation occurs and the progress against documented goals is not always included in the interRAI assessment comments.</p>	<p>Of the files reviewed, evaluations have not always been completed in a timely and comprehensive manner. Records reviewed showed no formal evaluation other than the interRAI re-assessment which did not indicate the response to documented interventions or progress towards documented personal goals.</p>	<p>Provide evidence evaluations are completed in a timely manner and indicate the degree of response to planned interventions and progress towards meeting documented personal goals.</p> <p>90 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA</p> <p>Moderate</p>	<p>The facility registered nurse/owner confirmed that care plan evaluations are incorporated into the interRAI re-assessments. There was evidence that care plans had been updated when obvious changes in health status occurred, including the need for assistance with feeding, mobility and personal hygiene for different residents. Short term care plans were used to document interventions related to short term problems such as infections and for wound care.</p> <p>However, as noted in 1.3.8.2, in five of six files reviewed the evaluation did not identify progress against documented goals, or the</p>	<p>Evaluation processes have not identified the severity of the level of change in every resident's needs; therefore, the level of detail in at least two service delivery plans lack sufficient detail to guide care. Referrals</p>	<p>Provide evidence that where evaluation identifies progress is different from expected, the service responds by initiating relevant changes to the service delivery plan(s), which shall include referral to</p>

		<p>level of change in the resident's condition. Consequently, there is a risk that not all changes in residents' conditions have been identified and included in the care plans, and that not all required actions have been taken. This concern was a reality for two people who were observed to be requiring interventions beyond those usually provided in a rest home facility. Staff and family interviews informed these two people have become increasingly dependent and updates to the care plans reflect that they now require two people assistance for personal cares and mobility. No referral for assessment by allied health had been made to advise on management strategies or any actions needed to develop a safe individualised manual handling plan for these residents. One person requires significant clinical interventions.</p> <p>The absence of comprehensive evaluations has meant there are gaps in the details of what is required for these two residents and for one of these residents, there was also no record of the significant impact any move out of the facility would have on the family, should this be required. Following progressive and significant declines in health and abilities, the rest home environment may no longer be the best service for these residents. The need for referrals for re-assessment by a suitably qualified allied health professional and/or Needs Assessment Service, to ensure they are receiving the correct level of care, has not been identified, or incorporated in the care plans of these two residents. The level of risk is mitigated from high to moderate due to the high level of staff commitment, the number of experienced staff available, how well the staff know these residents and the level of family involvement, especially for one person.</p>	<p>for reassessment by a suitably qualified health professional or the Needs Assessment Service have not been initiated when indicated.</p>	<p>suitably qualified health professionals and/or the Needs Assessment Service to review the needs of the resident(s) when indicated.</p> <p>90 days</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.