

# Heritage Lifecare (GHG) Limited - Somerfield House

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Heritage Lifecare (GHG) Limited

**Premises audited:** Somerfield House

**Services audited:** Dementia care

**Dates of audit:** Start date: 31 August 2020 End date: 1 September 2020

**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:** 39

# Executive summary of the audit

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## 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

Somerfield Rest Home (formerly known as Somerfield House) provides dementia care for up to 41 residents. This service is operated by Heritage Lifecare, Golden Healthcare Group Limited HLL (GHG). There is an on-site manager and a registered nurse who are overseen by a five-member executive team including a general manager and a clinical manager. Family members spoke positively about the services provided and residents said they were happy.

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

This audit has resulted in two continuous improvement ratings in relation to good practices around changes within the environment and the activity programme for people with dementia and one for the culture of quality improvements, which has seen positive results for some residents with the use of food moulds, managing family and resident relationships during the recent pandemic lockdown and a reduction in the number of residents' falls.

## 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.

Residents and their families/whānau are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these were observed to be respected. Services are provided in a way that supports personal privacy, independence, individuality and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents, and family/whānau is promoted and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and family/whānau with appropriate information required to make informed choices and give consent.

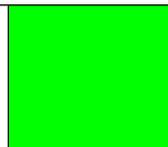
Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints and compliments system is in place and a complaint register is maintained and demonstrated that complaints were resolved promptly and effectively. Complaints are considered as an opportunity for quality improvement.

## 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.

A strategic plan includes the scope, mission, vision, values, goals and monitoring systems within the organisation. Monitoring reports are provided to the executive management team on a regular basis. An experienced and suitably qualified person manages the facility.

The quality and risk management system is described within a quality plan and allied documentation. This included collection and analysis of quality improvement data from which trends are identified and improvements are made. Feedback processes from staff, residents and families are in place and staff were familiar with, and involved in, the quality and risk system. Incidents and accidents are documented, related information is analysed and corrective actions implemented when indicated. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support safe service delivery and management processes. These are reviewed regularly and were current.

The appointment, orientation and management of staff is based on current good practice. Staff are supported to undertake both internal and external ongoing training opportunities. Topics intended to support safe service delivery are identified and arrangements for delivery made. Regular individual staff performance appraisals are being completed. Staffing levels and skill mixes meet the changing needs of residents.

Residents' information was accurately recorded, securely stored and not accessible to unauthorised people.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family/whānau.

Residents' needs are assessed on admission by a multidisciplinary team, including a registered nurse and general practitioner. Care plans are individualised, based on a comprehensive range of information and accommodate any problems that arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular basis within required time frames. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of meaningful activities for both individuals and groups while maintaining links with the community.

Medicines are safely managed and administered by staff that are competently trained.

The food service meets the nutritional needs of the residents with special requirements catered for. Food is safely managed and residents expressed satisfaction with the meals.

## 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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The facility meets the needs of residents with dementia and a safe, stimulating, accessible environment has been established both inside and outside for the people living there. There was a current building warrant of fitness and the facility was clean and well maintained. Electrical equipment has been tested and bio-medical equipment calibrated as required. Communal and individual spaces are maintained at a comfortable temperature and there is sufficient room for people to move around easily.

Waste and hazardous substances are well managed. Staff use the protective equipment and clothing, which is readily available. Chemicals and potentially dangerous equipment are safely stored. Personal laundry is undertaken onsite with household linen laundered by an external contractor. Cleaning and laundry processes are evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised, and fire safety equipment is monitored according to requirements. A call bell system is in place and staff are aware of the security systems.

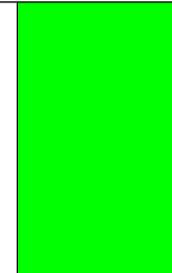
## Restraint minimisation and safe practice

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. Staff are trained in the use of such equipment and they reported their familiarity with the difference between a restraint and an enabler and the processes around their use. A restraint coordinator is aware of all aspects of this standard. There has not been any use of an enabler or a restraint in this facility for at least six years.

## 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, led by a trained infection control coordinator, aims to prevent, control/contain, and manage infections. The programme is reviewed annually. Specialist infection and control advice is accessed as required.

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 implemented when needed.

## 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)
<b>Standards</b>	1	44	0	0	0	0	0
<b>Criteria</b>	2	90	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	Somerfield Rest Home has implemented policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and gave examples of how they integrated them into everyday practice, such as knocking before entering a resident's room. Care staff were observed providing options and maintaining dignity and privacy. Training is included during the induction process of new employees, and on an annual basis (last held 23 June 2020).
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Family/whānau were informed of the importance of having Enduring Power of Attorney (EPOA) in place and activated through the admission information pack. Seven files reviewed had EPOA signed and accompanied by a Health Practitioner's Certificate of Mental Incapacity.  Informed consents were gained appropriately using the organisation's standard consent form. Advance care planning and establishing and documenting processes for residents unable to consent is defined and documented. Staff were observed seeking consent during daily cares.

<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>	<p>FA</p>	<p>During the admission process, residents/families are given information on the Advocacy Service. Brochures were also displayed at reception. Family/whānau spoken with were aware of the Advocacy Service, how to access this and their right to a support person but had not felt the need for it.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maintain their links with their family and the community by attending organised outings, visits, activities, and entertainment when appropriate. Family/whānau expressed that staff had kept them well informed of activities for the residents during 'lockdown', including video calls, and posting cards to family members.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code and included the expected response timeframes. A risk management matrix and flow chart were attached. Information on the complaint process is provided to residents/families on admission and family members interviewed knew how to do so.</p> <p>The complaints register reviewed showed that three complaints have been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within the required timeframes. Action plans and quality and risk meeting minutes showed any required follow up and improvements have been made where possible and that information on advocacy services had been supplied as appropriate. One of the more recent complaints was complicated and records showed that external support and advice had been sought to facilitate resolution.</p> <p>The clinical manager of the executive team, in consultation with the manager of the facility, is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service</p>	<p>FA</p>	<p>Residents/families/whānau interviewed were aware of the Code and had received opportunity to discuss it with staff. They received a copy of the Code, and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information pack. The Code was displayed in the main foyer</p>

<p>Delivery</p> <p>Consumers are informed of their rights.</p>		<p>and brochures were available at reception, together with information on the Advocacy Service, and complaint/compliment forms.</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>	<p>FA</p>	<p>Residents/families/whānau confirmed that they received services in a manner that has regard for their personal privacy, dignity and respect. Staff were observed offering choices and encouraging independence in activities of daily living. Care plans included documentation relating to the residents' abilities and strategies to maximise independence.</p> <p>Seven files reviewed demonstrated evidence of information on each resident's individual cultural, religious, and social needs. These were incorporated into their care plans.</p> <p>Staff understood the service's policy on abuse and neglect and were familiar with the process if signs were observed. Education sessions are held on abuse and neglect on a biannual cycle, along with management of challenging behaviours (November 2019). Families/whānau interviewed had never witnessed any form of abuse, neglect or discrimination.</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>	<p>FA</p>	<p>On the day of audit there were two residents who identified as Māori. They were well supported by staff to integrate their cultural values and beliefs into everyday life. At the time of audit, there was no cultural advisor for Somerfield, but emails were sighted arranging a meeting with one that had been delayed by isolation restrictions due to Covid-19. A Māori health plan was available from the previous advisor. The two Māori residents had a cultural profile, resource booklet, information on the Treaty of Waitangi and a word/picture glossary of everyday words. Cultural safety education was held on 22 January 2020 and included a quiz for staff to complete. These residents were interviewed and expressed satisfaction that their cultural needs were met in a sensitive manner.</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>	<p>FA</p>	<p>Seven files reviewed confirmed that information was gathered on their individual culture, values and beliefs, that that these were incorporated into their care plans and staff were observed respecting these. For example, a Chinese resident likes to use chopsticks. Residents/families/whānau expressed that needs were met in a sensitive manner.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff were observed to be treating residents in a respectful manner and calling them by name. Residents/families/whānau interviewed confirmed that staff were respectful and responded to residents in a dignified manner. The RN reported that there had been no incidents or complaints around abuse, neglect, or discrimination. During orientation staff receive education on professional boundaries and expectations required of staff in the Code of Conduct, and ongoing education occurs biannually. Staff are guided by policies and procedures and demonstrated a clear understanding of the process to follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>The service encourages and promotes good practice through evidence-based policies and input from external specialist services, for example, dietitians and a wound clinical nurse specialist. The general practitioner (GP) confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>The RN interviewed reported that she was well supported in her role, as the Golden Healthcare Group organisational structure has a senior RN providing oversight and guidance over two or three rest homes. External education is offered and access to online training is available.</p> <p>Somerfield Rest Home has created spaces related to residents' interests with interactive aspects that allow family and staff to encourage residents' to engage in a positive manner with meaningful activities.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Families/whānau stated they were kept well informed about changes to their relative's status and were advised in a timely manner about any incidents or accidents, as well as the outcomes of regular and urgent medical reviews. This was confirmed in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>The RN was aware of the process to access an interpreter but this had not been required. One non-English speaking resident received help from family members.</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>	FA	<p>Somerfield Rest Home is operated by Heritage Lifecare (Golden Healthcare Group) Limited, otherwise referred to as HLL (GHG). Currently the facilities under the HLL (GHG) management structure use Golden Healthcare Group policies and procedures and have their own strategic business plan. The strategic plan 2020 – 2025 is reviewed annually. This provides an overview of the organisation and states its purpose as being to provide a high standard of quality care in modern, purpose-built facilities. The scope of services provided in the various facilities is described and a set of goals refers to the achievement of external audits, ideal occupancies and ongoing monitoring of the various services provided. There is an overview of the</p>

		<p>structure of the organisation noting the executive team is comprised of the general manager; operations manager/human resources and compliance manager; administration manager; clinical manager and quality assurance manager. The maintenance manager and head gardener are responsible for managing all maintenance and gardening requirement including Somerfield Rest Home. A 'strengths, weaknesses, opportunities and threats' (SWOT) analysis has been undertaken and included in the strategic plan, which also includes a marketing strategy.</p> <p>The facility has a manager and a registered nurse who are responsible for ensuring the smooth and efficient management of the facility. Its mission is to provide quality care for the residents, catering for their physical, mental, spiritual, social, emotional and cultural needs, in a residence where they are cared for as unique individuals who merit the highest respect.</p> <p>A sample of minutes of executive team meetings, meetings of all GHG facility managers with the executive team and meetings with clinical staff, facility managers and the executive team were reviewed. The general manager confirmed during interview that these meetings complement monthly reports which enable him to maintain awareness of financial performance, emerging risks and any issues a facility may be dealing with. In addition, the general manager described the ongoing links with the management of Heritage Lifecare.</p> <p>Somerfield Rest Home has its own manager who has been in the role for 11 months. Their responsibilities and accountabilities are defined in a position description and an individual employment agreement. The manager has had extensive experience in the aged care sector, home and community services and in management roles, which was confirmed in their personnel file. During interview the manager confirmed knowledge of the sector, regulatory and reporting requirements. Records demonstrated the manager's attendance at a range of in-service education, in addition to attending contract related meetings with the DHB, aged care updates and relevant conferences.</p> <p>The service holds contracts with the district health board to provide rest home care, dementia, including respite care. Thirty nine of the 41 beds were occupied on the day of audit.</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</p>	<p>FA</p>	<p>A relieving manager from the Golden Healthcare Group team will take over the management of Somerfield Rest Home when the manager has a planned absence, otherwise the registered nurses will take on management responsibilities and carry out required duties under delegated authority. Additional support is available from members of the HLL (GHG) executive team and from managers of other facilities within the organisation.</p> <p>During absences of key clinical staff the clinical management is overseen by other registered nurses who work in the facility. Additional support may be accessed from the clinical manager of the HLL (GHG) executive team. Registered nurses reported during interview that they feel well supported and the current arrangements work well.</p>

services to consumers.		
<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>	FA	<p>The organisation has a planned quality and risk system that it is well documented (last updated 31 December 2019) and reflected the principles of continuous quality improvement. This is coordinated by an experienced quality manager who is also a member of the GHG executive team.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the executive management team meetings, at the organisational quality and risk team meetings and at Somerfield Rest Home management and staff meetings. Quality and risk meeting minutes included area reports as well as reports from each department including housekeeping, clinical, activities, for example. Other topics covered included internal and external auditing, incidents/accidents, health and safety/hazard management, training, emergency management and infection control. There was evidence of corrective actions being identified and followed through for any shortfalls, potential and actual risks being identified and managed and of quality improvement initiatives being instituted. The manager is responsible for identifying quality improvement opportunities and for following these through to completion with the team; however, the quality manager actively supports these projects. There were multiple examples of these, and a continuous improvement has been allocated for the service provider's dedication in enhancing the lifestyles of the residents.</p> <p>Family satisfaction surveys are completed annually, and the information is analysed. The most recent survey undertaken March 2020 showed 99% satisfaction in all areas. A resident feedback process includes monthly interviews with each person during which their responses were recorded. Information obtained through these processes is used to identify areas for improvement and opportunities for new projects.</p> <p>Policies reviewed covered 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 were current with the latest update being February 2020. A document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The clinical manager for the organisation reported working with HLL on a project towards combining Golden Healthcare Group and Heritage Lifecare Limited policies and procedures.</p> <p>A comprehensive risk management register for 2020 includes risk action plans and review processes. All projects and quality improvement initiatives have their own risk action plans. The manager and the quality manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. There is a health and safety manual available and the manager is familiar with the Health and Safety at Work Act (2015) for which the requirements have been implemented.</p>
Standard 1.2.4: Adverse	FA	<p>Policies and procedures on adverse event reporting are available. Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully</p>

<p><b>Event Reporting</b></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>completed, incidents were investigated, action plans developed, and actions are followed-up in a timely manner. Adverse event data is collated, categorised, analysed and reported by both the manager at Somerfield Rest Home and by the quality manager at the Golden Healthcare Group level. Quality and risk meeting minutes included summaries of these processes, any trends identified and any recommended corrective action or quality improvement follow-up. Information resulting from these analyses is shared with staff who confirmed during interview that they understand the graphs provided and find the updates useful.</p> <p>The manager described essential notification reporting requirements, including for significant infections, unexpected deaths and pressure injuries, for example. They advised there have been no notifications of significant events made to the Ministry of Health, or District Health Board, since the previous audit. There has been liaison with the DHB, especially the public health unit, regarding information related to the Covid-19 pandemic.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, pre-employment interviews and validation of qualifications and practising certificates (APCs), where required. A sample of staff records were reviewed and confirmed the organisation's policies are being consistently implemented and records are maintained. Staff records and training processes are a component of the internal audit system.</p> <p>There are a range of orientation checklists according to the different staff roles and responsibilities. All staff orientation includes the necessary components relevant to the specific role. Staff reported that the orientation process prepares new staff well for their role and timeframes are adjusted depending on previous experience. The staff records reviewed showed documentation of completed orientation.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements, which are clearly documented. A training schedule for 2020 was sighted and the manager informed that the development of workbooks on a range of training topics has facilitated their ability to ensure staff have remained up to date when they have been unable to attend a specific session and during the recent Covid-19 lockdown when trainers were not able to visit the facility. 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. A staff member within the wider organisation is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education with 20 of the 22 having completed these requirements and two new caregivers about to commence the required training. Caregivers are being given the opportunity to undertake both level three and level four of the national certificate if they choose and staff interviewed spoke positively about this.</p> <p>All three of the registered nurses working at Somerfield Rest Home informed they have a current competency to undertake interRAI assessments, which was confirmed in records reviewed. Annual</p>

		performance appraisals are up to date for all staff who have been employed at Somerfield Rest Home for at least one year.
<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>	FA	<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). A separate rostering policy details requirements at the facility level. The facility adjusts staffing levels to meet the changing needs of residents and reports of this occurring were provided. The manager noted that this need may arise when they are waiting for a person to be re-assessed. All new staff are buddied until they are considered to be confident and competent by the manager.</p> <p>The manager is on call 24/7 and this role is delegated to a relief manager in the event of sickness and annual leave. An after-hours registered nurse on-call roster is in place for clinical enquiries. Care staff reported that there is good access to advice when needed and that it may get busy at times but there were adequate staff available to complete the work allocated to them. Family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Agency staff is used as a last resort only and when needed people familiar with the residents at Somerfield Rest Home are requested. All except new staff have a current first aid certificate, therefore the facility has no difficulty in ensuring at least one staff member on duty has a current first aid certificate. The rosters detail the person responsible for medicine administration on each shift and this person has overall responsibility for the shift in the absence of the manager and/or a registered nurse.</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>All necessary consumer information was sighted in the residents' files reviewed. Clinical notes were current and included input from the nursing staff, diversional therapist, dietitian, and GP. Records were legible with name and designation of person making the entry identifiable.</p> <p>Archived files are stored securely on site and are readily retrievable if required. No personal information was on display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Specialist referral to the service is confirmed. Prospective residents and their families are encouraged to visit the facility. At this time, they are provided</p>

<p>services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>with an information pack and discussion around EPOA activation is held.</p> <p>Family members confirmed they were satisfied with the information process and the information that had been made available to them on admission. Seven files reviewed contained complete demographic detail, assessments and signed admission agreements in accordance with contractual requirements. EPOA documentation was complete with activation letters sighted.</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>	<p>FA</p>	<p>The service uses the DHB's yellow envelope system to facilitate transfer of residents to and from acute care services. At the time of transition between services appropriate information is provided including deescalating strategies for those with dementia, if required. A telephone handover is given to assist with smooth transitions. Documentation of a resident who recently went to the DHB confirmed that the family had been informed of the transfer.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and in line with the Medicines Care Guide for Residential Aged Care. An electronic system is used at Somerfield Rest Home to provide a safe system of medication management. Staff observed demonstrated a clear understanding of their roles and knowledge of responsibilities related to each stage of medicine management. Senior care staff administer medication after completing a medication competency, that is renewed annually.</p> <p>Medications are supplied in blister packs from a contracted pharmacy. Senior staff check medications into the facility on arrival and they are stored in a locked medication trolley in the treatment room. Non packaged medicines are stored in a locked cupboard and stock rotated. All medications sighted were within current use by dates. Unused medications are stored in a locked cupboard for pick up by a contracted pharmacy.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register showed evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>Temperature records for the medication fridge and medication room were within accepted range.</p> <p>Prescribing practices showed requirements for pro re nata (PRN) medicines. Three monthly reviews were completed by the GP and recorded on the medication chart. The GP is able to access the electronic system so verbal orders are not used. There are no residents who were self-administering medications at the time of audit.</p> <p>Medication errors are handled in an appropriate way.</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 food service at Somerfield Rest Home is provided on site by a team of qualified cooks and kitchen staff, and is in line with recognised nutritional guidelines for older people. The menu rotates over summer and winter patterns using fresh produce delivered daily. A qualified dietitian has reviewed the menu and made recommendations that have been implemented. The menu was last reviewed in March 2020. Kitchen staff have completed relevant food handling certificates. Ministry for Primary Industries have approved the food safety plan which was current until 2 July 2021. All aspects of food procurement, production, preparation, storage, transportation, and disposal comply with current legislation and guidelines.</p> <p>A nutritional profile is taken on admission and updated six monthly, or sooner if required. This includes allergies, likes/dislikes, modified texture requirements and these are accommodated in the daily meal plan. For those requiring modified textures the food is placed in silicone moulds that resemble the shape of the food before serving maintaining the residents' dignity. Residents have access to food and fluids to meet their nutritional needs at all times.</p> <p>Evidence of resident satisfaction with meals was confirmed through resident and family interviews, resident meeting minutes and satisfaction surveys. Observation of a meal time showed the residents received adequate time to eat their meals in an orderly and calm environment.</p> <p>The kitchen provides cakes for residents' birthdays, celebrations, and theme days run by the activities coordinator.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The RN confirmed that NASC assessments have been accurate regarding level of care and entry to the facility has been appropriate. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident/family/whānau and GP. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	<p>FA</p>	<p>Information is gathered within required timeframes using validated nursing assessments, such as mobility/falls risk, cognition/behaviour, pain, nutrition profile and current abilities. These are used to complete individualised and personalised care plans. A detailed activities profile is completed by the Diversional Therapist with interventions covering the 24-hour period including de-escalating tools and activities to occupy the resident. All interRAI assessments were current and completed within required time frames. Resident/family/whānau interviewed confirmed their involvement in the assessment process.</p>

manner.		
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The seven care plans reviewed reflected the support required by residents and outcomes of the integrated assessment process along with clinical information. The needs triggered during interRAI assessments were consistently evidenced within the care plans. Behaviour management plans including triggers and interventions for behaviours were observed.</p> <p>Integrated documentation was evidenced with input from the GP, nursing notes, diversional therapist, physiotherapist and podiatrist. Changes in care have been added to the care plan and were signed and dated, with this information handed over at changes of shift handover.</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, observations, and interviews confirmed the provision of care provided reflected residents' needs, goals and the plan of care. Care plans were personalised to individual resident's needs. The GP interviewed expressed that medical intervention was appropriate, orders completed and that the level of care was exemplary. Care staff spoken to confirmed that changes in care were passed on and implemented.</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 under the leadership of a qualified diversional therapist and an activities officer (who has commenced training) covering seven days of activities. They are well supported by the facility manager who is very involved in the programme. Care staff also play an active role in keeping the residents occupied. In spite of restrictions from Covid-19, Somerfield Rest Home has continued to offer a varied and appropriate programme that is meaningful to the residents and meets their needs in relation to age, culture, and abilities. A weekly programme offers such things as quizzes, exercises, crafts, games and outings when permitted. Activities that reflect normal patterns of life include baking, gardening and sorting clothes. In conjunction with the activities programme, a music therapy project is being developed.</p> <p>A social profile/history is collected from the resident and family members on admission to ascertain residents' needs, interests, abilities and social preferences. Activities assessments are reassessed six monthly and evaluated to ensure activities remain appropriate and stimulating to the residents. Resident family meeting minutes and satisfaction surveys along with resident/family/whānau interviews reflected positive responses to the programme. A "Let's Connect" programme is being established with joint activities involving other rest homes. The first event was held in February 2020 and was very successful with further developments recognised. Due to Covid-19 restrictions, this has been put on hold. Another initiative is music therapy using resident's choice of music and headphones as a means of de-escalating behaviours. Initial evaluation is showing positive results and all staff are being encouraged to try music before giving medication for</p>

		challenging behaviour and this is now being linked into care plans.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' 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 evaluations occur six monthly alongside interRAI reassessment, or sooner if a resident's needs changes. Where progress differs from expected outcomes then changes are initiated in the LTCP which are signed and dated. STCPs were sighted for weight loss management showing evidence of dietitian involvement, increase in weight monitoring, and intervention such as the use of nutritional supplements. These were reviewed and evaluated weekly and either signed off as resolved or transferred to the LTCP if it was an ongoing issue. Family/whānau interviewed confirmed they were included in any changes and the evaluation process.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents receive support from other health and/or disability service providers when required. Referrals were sighted for weight loss and specialist wound care management. Family/whānau were kept updated of the process and any interventions. Any acute referrals are attended to immediately, such as transferring the resident to accident and emergency department in an ambulance if required.
Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. General rubbish and recyclable cardboard are placed in skips and removed by a contractor on a weekly basis. Two recycling bins are put out weekly for council collection. Infectious waste is placed in the yellow bag and removed by the contractor with the general rubbish. Plumbers clean a grease trap near the kitchen area approximately three monthly.  An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff as part of the in-service programme. Chemicals and cleaning products were stored in the two laundries which are only accessible via a key code. Material safety data sheets were available where chemicals are stored and the housekeeper interviewed knew what to do should any

<p>during service delivery.</p>		<p>chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment including masks, plastic and rubber gloves, face shields and goggles. Staff were observed using these items as appropriate.</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 (expiry date 1 April 2021) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free and resident safety was promoted.</p> <p>An internal courtyard and a fenced back garden were available for residents to mobilise around. External areas are safely maintained and were appropriate for people with dementia with items such as a wheelbarrow and bicycle secured.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. A maintenance book is used to record any repairs required and the maintenance team leader signs and dates the entries as they are completed. Tradesmen are contacted when required. Residents were observed to interact with their environment and the items within it. Family members were happy with the environment and had no concerns.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. These include an ensuite bathroom with a shower for each bedroom. Appropriately secured and approved handrails are provided in all toilet/shower areas. Other equipment/accessories are available to promote residents' independence. Privacy locks have not been installed on bathrooms in resident areas for their safety. Staff informed they monitor communal bathroom use.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation except for one room in each wing which is a shared room. The manager informed these are seldom used but there is a process of approval from family members when they are. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids. Staff reported the adequacy of bedrooms but also noted the challenges of some residents entering other residents' rooms uninvited.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. There are quiet areas at the end of each wing where residents can go for privacy, as well as a sitting area beside the courtyard. A shed in the internal courtyard known as the 'Man Cave' is a retreat for some of the men in particular. Furniture is appropriate to the setting and residents' needs. Residents are free to move inside and outside as they choose.</p> <p>Over the last six months, the staff, led by the divisional therapist and the manager, have decorated the hallways using themes that are consistent with the interests of the residents living in that area. With support from family members and creative ideas, the decorations not only brighten the facility but provide visual and tactile stimulation to the residents. The decorations varied from flower boxes, nautical themes, sport and travel, for example (refer Standard 1.1.8).</p>
<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>	<p>FA</p>	<p>The facility has a dedicated laundry with a housekeeper responsible for their operation on each of the two wings. Weekend and night staff assist as needed. The laundering of towels, bed linen and infectious items is undertaken by a contractor with personal clothing undertaken on-site. During an interview with a housekeeper it was clear they had a sound knowledge of laundry and cleaning processes. A dirty/clean flow process was evident in the laundry, cleaners and laundry products were labelled and stored safely and there were good supplies of personal protective equipment. Family members are satisfied with the management of their relative's laundry, although one family member now takes woollens home after an item was shrunk.</p> <p>The housekeeper in each wing is also responsible for the cleaning of the facility. Both wings have a relief cleaner/laundry person during the weekend. Staff training records confirmed reports that the laundry/cleaning staff have completed training on handling chemicals provided by an external agency. The person interviewed described processes used to monitor cleaning products when and resident areas.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. A laundry audit undertaken 18 August 2020 had no corrective actions to be implemented. The housekeeping internal audit on 4 August 2020 identified one area for corrective action, which is currently being rectified. The manager and housekeeping staff informed that extra hours had been allocated to laundry and cleaning duties during</p>

		the recent Covid-19 pandemic alerts.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. Staff confirmed their awareness of the emergency procedures and informed they receive regular training on fire and emergency management. The current fire evacuation plan was approved by the New Zealand Fire Service on 6 June 2006. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 7 July 2020. The orientation programme includes fire and security training as does the six monthly fire drills. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, blankets, mobile phones and gas BBQs were sighted and meet The National Emergency Management Agency recommendations for the region. Checks on emergency supplies are undertaken six monthly. There is sufficient water stored throughout the complex and as cookware is operated by gas this would be available in most instances. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis with the last one being August 2020. Residents and family members were not able to confirm response times to call bells, however staff reported their infrequent use ensures they are even more alert when they are used.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. There are heat pumps in corridors and communal areas, convection heaters in residents' rooms and electric heating in both lounges that give the appearance of a fireplace. Rooms throughout the facility have natural light, opening external windows and security latches are in place. Hallway doors open onto a secure garden area at the rear and an internal courtyard. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. Internal air temperatures are checked monthly by maintenance staff.</p> <p>There is a safe external designated smoking area for residents and another for staff. Residents are supervised if they choose to smoke.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to control and contain the risk of infection to residents, staff, and visitors. The programme is supported by a comprehensive and current infection control manual. The IPC programme is reviewed annually by the IPC coordinator and IPC clinical manager who oversees the organisation's sites. The programme was last reviewed 12 February 2020.</p> <p>A job description was sighted for the IPC coordinator. All infection control matters including surveillance are reported to the IPC clinical manager monthly and quality meetings.</p> <p>Under level 2 restrictions visitors are let into the facility and complete a Covid-19 checklist, have their temperature taken and use hand sanitiser. Masks are worn when physical distancing is not possible. Staff are aware if they are unwell, they must remain off work until symptom free for 48 hours.</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>	<p>FA</p>	<p>The IPC coordinator has appropriate skills and training to implement the programme and accesses additional support from the GP and DHB if needed. During Covid-19 restrictions, support was provided through the New Zealand Aged Care Association and the Ministry of Health.</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</p>	<p>FA</p>	<p>The IPC policies are in line with good practice and meet legislative requirements. Review of policies occurred in February 2020 and the clinical manager stated they were reviewed annually.</p>

appropriate/suitable for the type of service provided.		
<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>IPC education has been increased due to Covid-19 with an emphasis on hand hygiene, donning and doffing personal protective equipment, pandemic response with both internal and external audits being performed. The staff interviewed were confident in understanding the requirements in place at this time.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of upper and lower respiratory tract infections, skin, gastro, wound and eye infections are monitored monthly and results analysed for possible causes, trends and required actions. New infections and any required management plan are discussed at handover so early intervention can occur. Graphs are produced and comparisons made for same time frame, in previous years, and against other facilities within the organisation. This is discussed at quality meetings and feedback provided to staff at handover.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. Appropriate documentation and reporting processes are in place should they be required. One of the registered nurses is designated as the restraint coordinator to provide support and oversight for enabler and restraint management in the facility. The restraint coordinator demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>There has not been any restraint or enabler use in this facility for at least six years. Staff, managers and the restraint coordinator informed that any form of restraint would only be used as a last resort when all alternatives had been explored. Observations on the day of audit, and conversations with the staff, demonstrated their commitment to use de-escalation techniques rather than any form of restraint. All spoken with expressed competence in managing behaviours that challenge.</p>

## Specific results for criterion where corrective actions are required

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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
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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, 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>One of the initiatives of the Diversional Therapy Action Plan is to expand themed areas to develop an environment that supports residents with dementia and enables them to participate in personalised and everyday social activities that are meaningful to them. The new manager and diversional therapist (DT) wanted to expand on themed areas and develop areas that reflected everyday activities. Resident meeting minutes, surveys of residents and innovative ideas from the manager and DT indicated that the themed areas were an underutilised resource. Combining their experience and ideas from such resources as memory lane therapy, the Golden Carers website, and the NZ Diversional Therapy Association, they commenced a continuous improvement project which has had positive impact on the quality of life for the residents of Somerfield.</p> <p>The environment and layout of the facility is conducive to developing spaces associated with memories/pastimes of residents. For example, there are spaces designed to reflect residents’ interests in gardening, sport, music, travel, Māori memorabilia, pets, butterflies, beach scenes and flower arranging. Each area had cushions, photos, books and tactile things to touch and feel, with appropriate</p>	<p>Continuous improvement was evident in relation to the environment that promotes good practice and encourages greater use of themed areas, that are safe and meaningful to the residents, and to provide areas that are conducive to promoting dialogue and interaction between the resident and staff and family members. Tactile elements were incorporated to promote meaningful actions of the residents and enhance quality of life. The spaces have been developed to be aesthetically pleasing and give residents a peaceful area to relax in.</p> <p>Evaluation has been through positive</p>

		<p>scenic walls behind the displays. Residents are able to and encouraged to rearrange, pick-up, touch or sit quietly in a place full of memories. Staff and family members are able to use the areas to stimulate conversations, as a diversion (if required), or to create a calming atmosphere. The scenes were developed after examining residents' social profiles which are completed by family prior to admission, resident surveys, feedback from resident meetings, and observation of residents' behaviour.</p>	<p>feedback from resident satisfaction surveys, resident meetings, photos of residents engaged and interacting in meaningful activities and everyday events. Feedback from residents' family/whānau has been extremely positive as it creates an opportunity for them to once again connect with family members.</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>CI</p>	<p>Somerfield Rest Home staff and managers have built a strong culture of quality improvement within their quality and risk management system. Information is obtained from a range of reporting systems varying from incident/accident reporting, infection data, internal audit results, family and resident feedback, and research-based information on dementia care. Projects with comprehensive action plans including evaluative measures are developed and implemented accordingly. In addition to the continuous improvement identified elsewhere in this report there are a number of other projects well underway that are targeted at improving the lives and experience of the residents. These projects have not necessarily been identified separately as they are mostly a work in progress; however, the processes in use and the results from evaluations to date are demonstrating continuous improvements, which are advantageous to groups of residents. Additional details relating to three specific projects follow.</p> <p>The three key examples of such projects are programmes specifically designed to reduce residents' falls, one on the use of food moulds and a preparedness planning action plan. This falls reduction project has a 'SMART' objective, commenced February 2020 and is scheduled to continue at least until December 2020. The six-month results that can be attributed to the planned interventions to date have shown a decrease in the number of falls in the dining room/lounge, in particular in one specific wing.</p> <p>A two-part preparedness planning action plan for the Covid-19 pandemic lockdown was implemented. This was intended to ensure the facility could manage should staff not be able to come to work or a case of Covid-19 occurred and to reduce the impact that the lockdown situation had on the mental, emotional and social needs of the residents. The plan was comprehensive, involved all staff, covered information distribution and the implementation of systems that would</p>	<p>Verbal reports, and documentation within the quality and risk management system, demonstrated that multiple quality improvement opportunities are being identified and developed into various projects with comprehensive action plans and progressive evaluation processes. These projects are progressively enhancing the environment and lifestyles of residents.</p>

		<p>enable family members to make contact and still be involved in the resident's care. Additional equipment was accessed to ensure the safety of residents with dementia as far as possible. The activity programme was reviewed with extra tabletop activities made up and resident involvement in the enhancement of the environment as mentioned in standard 1.1.8 above. Evaluation outcomes demonstrate that not only is the facility prepared for a case of Covid-19 going forward, but more importantly the ideas used to help residents maintain links with their family members in a meaningful way during the lockdown were effective.</p> <p>Another project with a comprehensive action plan and review process was around the use of food moulds for some of the residents on puree diets. Progressive weight loss and a disinterest in eating were observed to be an emerging concern for some residents who had been prescribed pureed diets. Referrals to dietitians had had limited effect. Research information and ideas from family members and staff were discussed and culminated in an action plan around the use of food moulds for puree vegetables and proteins. Results to date are variable as some people have been placed on the programme more recently and it is still too early for the results to be reliable regarding. However, there is measured evidence in the three-monthly reviews since January 2020 that at least three people are now at least maintaining their weight with reports of minor gains.</p>	
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End of the report.